A GUIDE FOR

SCHOOL HEALTH ADVISORY BOARDS:

PROMOTING HEALTHY YOUTH

Commonwealth of Virginia
Department of Education
Richmond, VA 23218-2120

Revised
May 2004

A GUIDE FOR

SCHOOL HEALTH ADVISORY BOARDS (SHABs):

PROMOTING HEALTHY YOUTH

Revised by:

Fran Anthony Meyer, Ph.D., CHES
Program Coordinator

Lois Sandy, RN, MS, Consultant Laura Wimmer, MS, Consultant

Virginia Comprehensive Health Education Training and Resource Center
Longwood University

In cooperation with:

Muriel Azria-Evans, Ph.D., CFLE
Comprehensive School Health Specialist
Virginia Department of Education

Lissa Power-deFur, Ph.D.
Director, Office of Student Services
Virginia Department of Education

Gwen Smith, R.N., M.S.N.
School Health Services Specialist
Virginia Department of Education

Vanessa Wigand
Health, Physical Education and
Driver Education Principal Specialist

Arlene Cundiff
Safe and Drug Free School Program
Coordinator
Virginia Department of Education

Carol Pollock, RN, MSN, FNP
School Nurse Consultant and
Adolescent Health Coordinator
Virginia Department of Health

Virginia HIV/STDS Resources Review Panel
Longwood University

Commonwealth of Virginia
Virginia Department of Education
May 2004

This manual is a revised version of a former 1995 publication:
A Guide to Establishing And Maintaining School Health Advisory Boards

Published by the Virginia Department of Education

Inquiries about the publication may be directed to: Dr. Muriel Azria-Evans, comprehensive school health specialist, at mazria-e@mail.vak12ed.edu or 804-225-4543. The publication may be obtained by contacting: Office of Student Services, Virginia Department of Education, P.O. Box 2120, Richmond, VA 23218. An electronic format may be obtained by logging onto the Virginia Department of Education's School Health Advisory Board Website at www.pen.k12.va.us/VDOE/studentsrvcs/shab.shtml or logging onto: www.longwood.edu/vchetrc/Data%20and%20Publications.htm

FOREWORD

Research literature shows there is a direct link between the health of young people and school success. There also are links between implementation of school health program components and student success in schools. Further, it is known that students are most influenced to lead healthy and productive lives when the schools, parents, and other community groups work cooperatively. Each of these groups has critical and unique roles, as well as strategies, for accessing students, identifying and sharing resources, and impacting on the behaviors of children and youth. However, the coordination of these efforts requires interacting and planning toward common goals.

The school health advisory boards can serve as the catalyst for systemic changes in schools and school divisions for promoting student health and educational outcomes. Local boards accomplish this role by serving as the communication and coordination link for consistent and focused short-term and long-range planning for the school community.

TABLE OF CONTENTS

Appendices

INTRODUCTION

Background

The promotion and protection of the health of students and the well-being of staff members has been a historic and ongoing task of schools across the nation and in Virginia. To increase this effort in the early 1990s, a Governor's Task Force on Child Health was formed. The Task Force recommended that the secretaries of education and health and human resources work together to encourage school divisions to increase the school's role in improving the health of children in the commonwealth. To reinforce the effort, the 1992 General Assembly amended and reenacted §22.1-275.1 of the *Code of Virginia* to require each school division to have a school health advisory board in place by December 1992. In 1999, the *Code* was further amended to suggest that local school boards request from their own school health advisory boards recommendations on procedures related to children with acute or chronic illnesses or conditions, including emergency procedures for life-threatening conditions, and designation of school personnel to implement the appropriate emergency procedures.

Research indicates that in order for students to take full advantage of the standards-based educational programs, they must be healthy so that they are ready to learn and can concentrate on learning while they are in school (e.g., Marx, Wooley, & Northrop, 1998). For more than a decade school divisions have utilized school health advisory boards to help foster family and community support and involvement in developing and implementing school health programs, including health instruction; healthy school environment; school health services; school counseling, psychological and social services; physical education; school nutrition services; and health promotion for staff members. This publication helps local school health advisory boards by providing strategies that can help them better integrate these health program components into the academic structure of their schools to benefit the well-being and learning of all students.

Local school health boards are organized to include no more than 20 members, with a broad base of representation including parents, students, health professionals, and educators. In addition, many boards have included parents and representatives from community agencies, the local school board, business and industry, child advocacy groups, volunteer health agencies, the school division staff, and institutions of higher education on subcommittees. Many school health advisory boards use a variety of local data from parents, students, and community agencies to set priorities and program objectives. Each board is required to meet at least semiannually and to report annually on the status and needs of student health in the school division, to any relevant school, the school board, the Virginia Department of Education, and the Virginia Department of Health.

Purpose of the Guide

This document, *A Guide for School Health Advisory Boards: Promoting Healthy Youth,* formally called *A Guide to Establishing and Maintaining School Health Advisory Boards*, is an updated publication of the Virginia Department of Education intended to assist school divisions and interested community members in continuing to meet requirements of § 22.1-275.1 of the *Code of Virginia* for maintaining and revitalizing their school health advisory boards. This *how to* manual aims to provide practical guidance in developing effective board practices and procedures for examining components of local school health programs, reviewing relevant school health policies, and making well-informed recommendations for change to specific schools, school division staff members, or the local school board.

OPERATIONS OF A SCHOOL HEALTH ADVISORY BOARD

Description of a School Health Advisory Board

A school health advisory board is an *advisory group* composed of individuals from broad-based segments of the community committed to creating healthy school environments so students may realize their learning potential. The school division generally appoints members of a school health advisory board.

The group is charged to act collectively to advise the school division on broad-scope topics or on certain aspects of the school health program, including children with disabilities, vocational education, mental health, school nutrition, dropout prevention, school safety, drug and alcohol prevention, or family life education. The subcommittee may research a topic and bring information to the board to develop recommendations for the school division.

School health advisory boards play an integral part in the successful implementation of community school reform initiatives, including coordinating components of school health programs. It is important to emphasize that school health advisory boards are formed to provide advice and to serve as advocates for particular school health concerns. These groups are not part of the administrative structure of the schools, nor do the groups have any legal responsibilities within the school division.

The Code of Virginia that lends support to the effort of promoting healthy youth in schools and communities states as follows:

> *Code of Virginia* § 22.1-275.1. School health advisory board. Each school board shall establish a school health advisory board of no more than twenty members, which shall consist of broad-based community representation including, but not limited to, parents, students, health professionals, educators, and others. The school health advisory board shall assist with the development of health policy in the school division and the evaluation of the status of school health, health education, the school environment, and health services.
>
> The school health advisory board shall hold meetings at least semi-annually and shall annually report on the status and needs of student health in the school division to any relevant school, the school board, the Virginia Department of Health, and the Virginia Department of Education.

The local school board may request that the school health advisory board recommend to the local school board procedures relating to children with acute or chronic illnesses or conditions, including, but not limited to, appropriate emergency procedures for any life-threatening conditions and designation of school personnel to implement the appropriate emergency procedures. The procedures relating to children with acute or chronic illnesses or conditions shall be developed with due consideration of the size and staffing of the schools within the jurisdiction. (1990, c. 315; 1992, c. 174; 1999, c. 570.)

Functions of a School Health Advisory Board

School health advisory board members facilitate understanding and cooperation among those interested in developing and improving the local school health program. In addition to their overall purpose of advising and supporting school health programs, school health advisory boards perform many other functions including:

Visibility for School Health: An active school health advisory board provides visibility for school health within the school division and community. Having an active board communicates to school personnel and community members a message of concern for the health of children and staff. In an era when schools have many complex and diverse goals to accomplish, the school health advisory board can serve as a reminder that health is also important for efficient school operations.

Parent and Community Involvement: A school health advisory board can promote parent, citizen, and professional involvement in the schools. A well-organized advisory board provides an opportunity for participation by parents in activities and decisions influencing the lives of their children. It also serves as a mechanism for involvement by other community members, including those from business, religious organizations, civic groups, human service agencies, city council members, or county supervisors.

Advocacy for School Health: The school health advisory board can conduct or facilitate activities that bring attention to the benefits of a high-quality school health programming. Such activities often generate further support and momentum for the school health program. Perhaps of equal importance to the group's work are the individual acts by current and former board members that cause others to become aware of the important role of each component of the school health program.

Forum for Health Issues: Often there are health issues affecting students and school staff members that need a specific place in the community for discussion, decision-making, and planning. Occasionally, these issues are controversial and require the opportunity for the presentation and consideration of different points of view. The school health advisory board can provide a positive environment for constructive reviews of issues through its meetings, subcommittee structure, and representatives.

Recruitment of Community Health Resources: The identification of needs in the school health program may require the participation of multiple community health resources. The school health advisory board can coordinate the involvement of individuals and agencies for a specific need in the school division.

Facilitate Understanding of Schools and Communities: Participation in school health advisory board activities provides opportunities for parents and other community members to gain further insight into the life of schools. Similarly, it allows school personnel to learn more about the varied backgrounds and the points of view within the community.

Public Relations: In addition to advocacy-related activities, many school health advisory boards function as an effective public relations extension of the school division. Informing the community and school personnel about aspects of the school health program can enhance the image of the school division. The involvement of media representatives and influential community decision makers within the school health advisory board has been an effective way of implementing this public relations function.

Facilitate Innovation: The school health advisory board can become an advocate for introducing new health program components in the school community. Through their advisory role, members can share special interests or approaches to components of the school health program with school personnel. In some situations, the school health advisory board may become the major financial and motivational supporter of change within the school division. Using this board as a sounding board for new approaches can be a valuable step in bringing school health issues to local or other decision makers.

School Division Personnel Responsibilities in Supporting the Work of School Health Advisory Boards

Implementation of successful school health programs can begin with the schools, the school division, or the school health advisory boards. Regardless of where ideas originate for development or revisions of school health policies, programs, or services, the support of the school division is critical for successful review and implementations of recommendations for change. The school health advisory board is dependent on the

leadership and support of the school division in maintaining its effectiveness as an advisory board. To strengthen the effectiveness of school health advisory boards, school division personnel should consider the following supportive actions:

- Promote the *Coordinated School Health Model*.
- Strengthen the communication channels among the school health advisory board, the school division personnel, the school board, and the community.
- Help the school health advisory board members increase their understanding of the existing school health program so that they may become advocates.
- Work with the school health advisory board to identify the general functions and areas of concern that need attention by the board, including a working definition of school health programming that is standard to all within the school division.
- Identify potential members (no more than 20) for the school health advisory board, the membership selection process, the length of terms, and the potential categories of membership (see #2 on page 16). Appoint members to the local board and acknowledge the value of their contributions.
- Designate a school division personnel member to serve as the primary contact for school health advisory board activities.
- Recognize and utilize the support of the school health advisory board in improving the school health program within the school division.

Guidelines for Recruiting Members

The following steps can be used to select and appoint members to the school health advisory board:

1. School health advisory boards may have up to 20 members. Members should be selected based on the following criteria:

   Interest and Involvement in Youth-Related Activities: Individuals with recent involvement in activities to help children and adolescents.

   Awareness of Community: A general understanding of the cultural, political, geographic, and economic structure of the community.

   Professional Abilities: Individuals with professional training in a youth-related field, such as individuals employed in human service agencies. However, training

and agency affiliation do not predict the value of the individual to school health advisory board activities.

Willingness to Devote Time: No matter what the person's qualifications and interest in youth, it is best to determine an individual's willingness to make time for the school health advisory board.

Representative of Population: The composition of the School Health Advisory Board should reflect the community based on age, sex, race, income, geography, politics, ethnicity, and religion. Careful selection can enrich the level of discussion, the credibility of the group in reflecting the views of the community, and the acceptance of proposed activities.

Respectability: The credibility of the school health advisory board is enhanced considerably by the personal characteristics of its members. Individual characteristics, such as honesty, trustworthiness, dependability, commitment, and ethics, all contribute to the character of the school health advisory board.

2. The executive committee of the school health advisory board or a small, diverse group of three to five concerned individuals should examine or re-examine potential members for each membership category from the following list:

Parents/Parent Groups
- PTA representative
- Parent of a special education student
- Parent of a medically fragile student

Health Professionals
- Child/adolescent psychologist or psychiatrist
- Dentist/dental hygienist
- Nurse
- Primary care physicians (pediatrics, family practice) or specialists (e.g., OB/GYN, sports medicine)
- Speech-language pathologist/physical therapist
- Audiologist, optometrist, optician
- Health educator
- Registered dietitian (if not available, nutritionist or work & family studies teacher)
- Hospitals/clinics (medical, dental)

Business/Industry

Volunteer health agencies/ Community services boards
- American Cancer Society
- American Heart Association
- American Red Cross

Churches/Synagogues
- Pastoral counseling

Public agencies
- Social service agencies
- Local health department representative; public health educator

Civic and service organizations
Colleges/Universities
    Faculty in health profession programs
Public media (print, audio, visual)
Attorneys and Law enforcement officials
Schools
    Student
    School health director/coordinator
    Health supervisor/coordinator
    School nurse (RN)
    Safe and drug free school (SDFS) coordinator
    School resource officer
    Guidance counselor
    Nutritionist (Cafeteria manager or work and family studies teacher)
    Principals (elementary, middle, secondary)
    Teachers (elementary, middle, secondary; health, physical education, science; teachers of children with disabilities)
    Custodian or bus driver
    Audiologist
    Speech-Language pathologist
Community youth groups
Professional societies with an interest in the health of children and youth
Local government officials

3. To protect the stability of the school health advisory board and to develop consistency in operations, new members should be assigned to staggered board terms of one, two, or three years.

4. The purpose of the school health advisory board, the board's general operational procedures, its current membership, and the time commitment expected should be explained prior to a potential member's first board meeting.

5. Confirm the new membership list with the designated school division contact person.

6. It is appropriate for the school superintendent or school board chair to send appointment letters to new members of the school health advisory board. The appointment letter could indicate appreciation for the person's willingness to participate on the school health advisory board, its purpose, the term of appointment, the frequency of meetings, the name of the school division contact person, and the school health advisory board chairperson (if known).

7. It is recommended that all members receive a copy of this publication, *A Guide for School Health Advisory Boards: Promoting Healthy Youth,* an updated membership roster, and an announcement of the next meeting.

Organizational Structure and Lines of Communication

School divisions may organize their school health advisory boards into a variety of structures and the interaction between structures may differ within neighboring school divisions. School divisions must decide on the process by which the school health advisory board will operate. Such decisions will likely reflect certain philosophical views regarding personal involvement in routine meetings, perceptions of school health programs in improving academic achievement, perhaps the role of the media in addressing school health and other educational issues, or the role of community members in supporting school programs. Such variables may help explain why a school health advisory board structure might work very well in one school division and not in another.

Care should be taken in determining the best structure and communications option for each school health advisory board. For example, in some Virginia communities the School Health Advisory Board also serves the local Safe and Drug-Free School Communities Act (SDFSCA) Advisory Council. The Virginia Department of Education supports combining advisory boards when communities find it more efficient and effective. Regardless of the organizational structure, the process should promote realistic and practical operational procedures.

Two common structures are described. The first, shown in **FIGURE 1**, is a community-based structure including groups such as PTAs, voluntary health organizations, community youth-serving agencies, and health professionals. The school superintendent and the school health administrator are members. The local school board that also appoints the school health advisory board is represented as a member of the advisory board.

Advantages of this structure are the direct communication link with the school board, the involvement of key school staff members in school health advisory board activities, and representation from a wide variety of community segments. Potential disadvantages include the danger of domination by school personnel and low interest levels among members who are there to represent their agencies rather than having personal interests in youth.

Figure 1

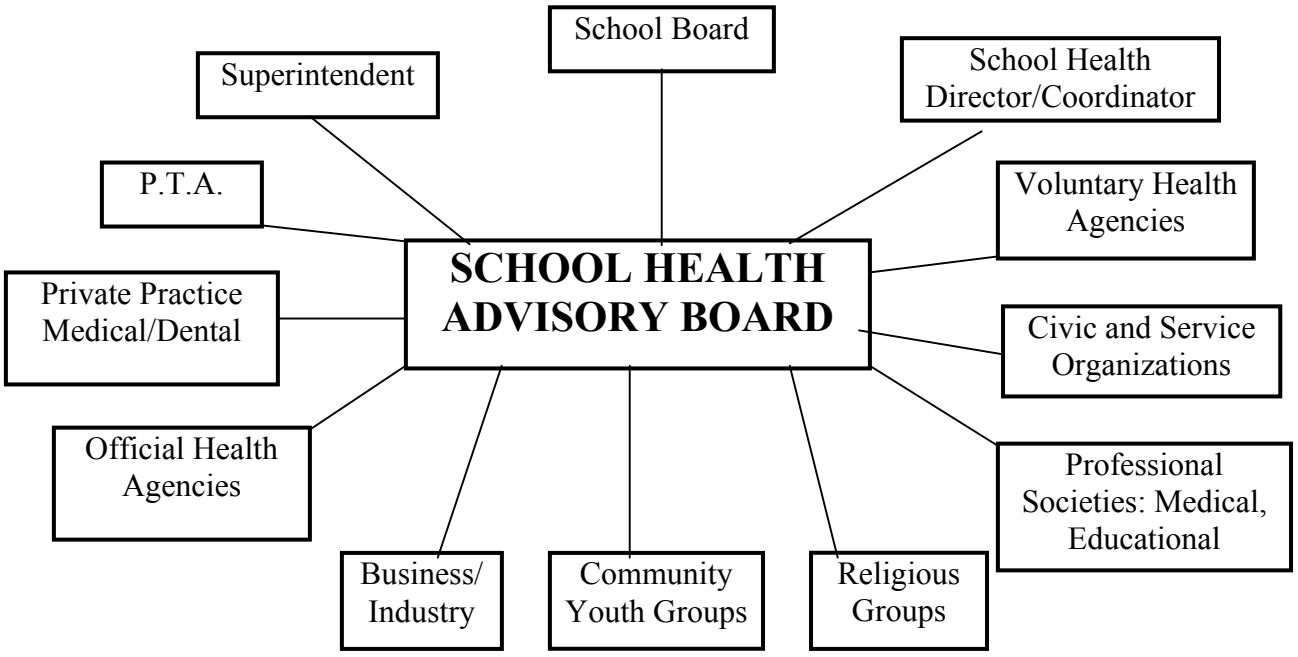
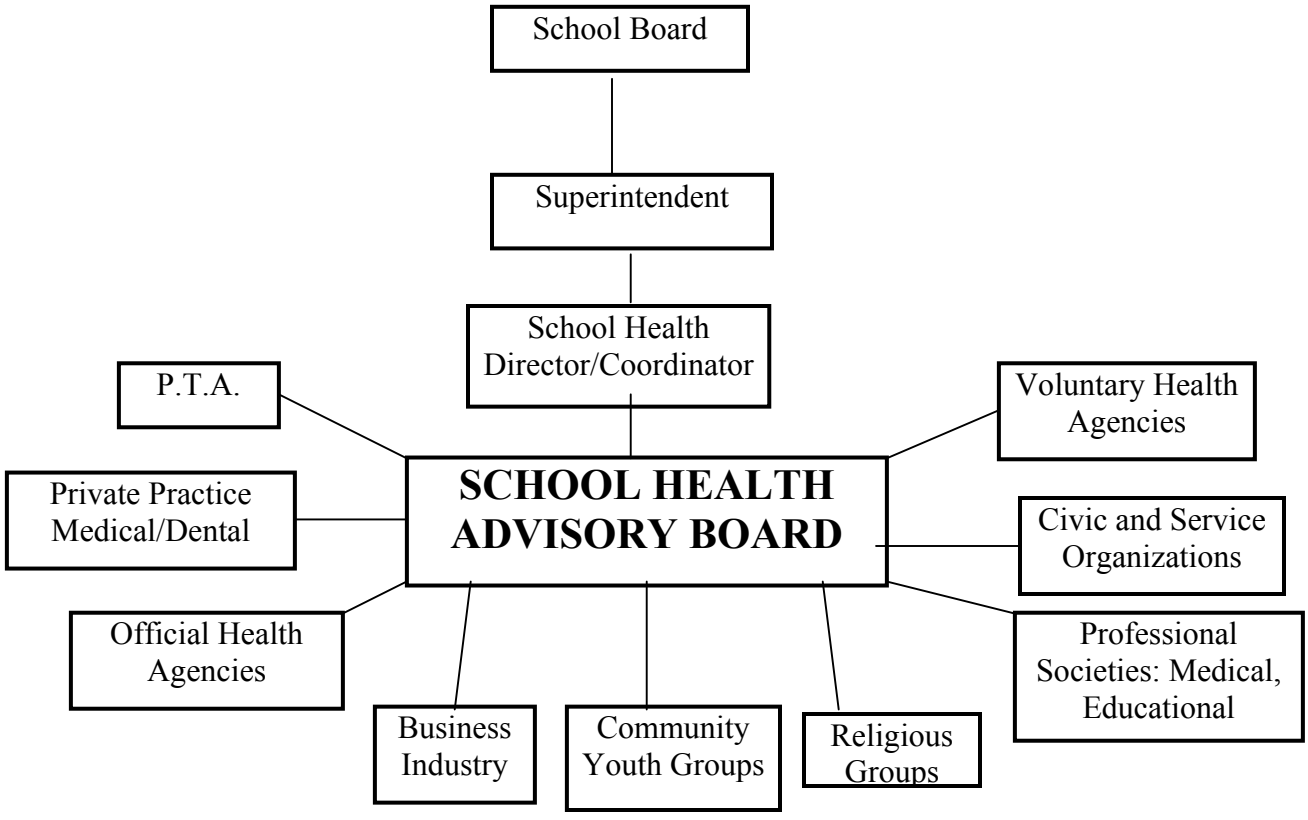

School Board
Superintendent
School Health Director/Coordinator
P.T.A.
Voluntary Health Agencies
SCHOOL HEALTH ADVISORY BOARD
Private Practice Medical/Dental
Civic and Service Organizations
Official Health Agencies
Professional Societies: Medical, Educational
Business/ Industry
Community Youth Groups
Religious Groups

FIGURE 2 illustrates another common arrangement in which the school health advisory board reports to a school health administrator, who reports directly or indirectly to the superintendent, who reports to the school board. The school health advisory board might have an elected chairperson and appointed members.

One advantage for this structure is that the school health advisory board may operate more independently than the one described in Figure 1. In addition, the structure allows for the orderly flow of information from the school health advisory board to designated persons in the school division. A disadvantage of this structure might be the filtering or amplifying of any reports as they move up the administrative ladder. This organization also potentially puts more distance between the school health advisory board and the school board.

Figure 2



As might be expected, there are other ways to organize the school health advisory boards. For example, some school divisions have small executive committees within the school health advisory board composed of a chair (co-chairs), vice-chair, and secretary or the school advisory board chair and chairs of each subcommittee may comprise an executive committee. The school health advisory board may use the executive committees to determine needs for the year. After deciding on project priorities, the

group then identifies individuals to work on each project. All individuals working on projects are viewed collectively as the school health advisory board. Although this approach may be effective in getting projects completed, it has the potential of failing to focus on a more comprehensive view of school health. Members may come and go without being exposed to a broader view of school health.

The school health advisory board structure and communication links with the school division and community should be clearly delineated for all participants. Similarly, school health advisory board members may suggest modifications based upon their experience to enhance the working relationship. As the school division and school health advisory board gain experience, it is likely that changes will be needed to facilitate the school health advisory board's purposes.

Operating Procedures/By-laws

Operating procedures or bylaws for a school health advisory board serve a number of useful purposes. Overall they clarify purpose, structure, and operational procedures, and serve to reduce confusion among members. When bylaws are in place and a strong leader leaves a board, it is easier for future leaders to proceed efficiently. These procedures provide guidelines for carrying out the board's business in order to accomplish its purpose(s). Minimally, the procedures should contain the following components:

Name and Purpose of the School Health Advisory Board: The name is most likely to be straightforward, simply incorporating the school division's name.

The purpose statement should reflect the advisory nature of the school health advisory board and the definition of school health. This definition will determine the boundaries or scope within which the school health advisory board will function. For example, some school health advisory boards define school health as K-12 classroom health instruction. Other school health advisory boards include any aspect of the health instruction, health services, and health environment**.** Still others use the broader model that includes these three components as well as school food services, physical education, school-site staff health promotion, family and community involvement, and school counseling, psychological, and social services.

Membership: Describe the composition of the school health advisory board in terms of the number of members, community sectors represented, terms of appointment, voting rights, termination, resignation, selection method, attendance, and criteria for eligibility. Identify a specified contact person within the school division who would have access to the current membership roster as well as any *ex officio* members (i.e., members holding an office or position that is created for

a specific purpose but does not impact voting status, unless explicitly provided otherwise).

Meetings: Specify the frequency, date, and location of meetings, as well as procedures for setting the agenda, notification of meetings, and distribution of agenda and minutes. The school health advisory boards may conduct meetings governed by *Robert's Rules of Order* or some equivalent. (Keep in mind that school health advisory board meetings are subject to open meeting laws.)

Officers: Provide the titles and responsibilities of officers, their terms, as well as a brief description of the election, removal, and resignation processes. Generally, the officers will be chairperson or co-chairpersons, vice-chairperson, secretary, and treasurer (as needed). Note: The school health advisory board chairperson is often the individual responsible for motivating and supporting members in their efforts to fulfill the group's purpose. Therefore, selecting an individual for this position is critical. An alternative is to select co-chairpersons, thereby allowing for the division or rotation of leadership tasks.

Voting Procedures: Describe the voting process used at regular meetings and the required quorum. For example, one half of the current members must be present for an official vote and two-thirds of those present must vote for a motion in order to approve the motion. Some school health advisory boards may require a waiting period (until the next meeting) before a vote is taken and that the motion be placed on the agenda as an action item.

Committees: Provide the names of standing committees or subcommittees with a brief description of their functions and membership. Also, describe the process for the formation of any special committees.

Communications: State the reporting procedures practiced by the school health advisory board for internal and external communications. Also include the method for determining the agenda, the identification of the school person or group receiving reports from the board, any regular procedure for informing the community about its activities, and the identification of a central location for storing past and current records of the school health advisory board activities.

Amendments: Offer an explanation of the process used in making amendments to the operating procedures. The operating procedures should be approved by the members, dated, and copies made available to all new members and appropriate school personnel.

Characteristics of School Health Advisory Board Members

Individuals with the following characteristics are more likely to be successful school health advisory board members:

1. Perceives schools as being influential in the lives of students and staff.
2. Is concerned about the health of children and adolescents.
3. Believes school health advisory board actions can have a positive influence in the schools and communities.
4. Understands the general organization of the schools and community.
5. Possesses personal characteristics conducive to positive and productive school health advisory board meetings and activities.
6. Is willing and able to make the necessary time commitment.
7. Have leadership skills necessary to be an advocate for children and adolescents.

Guidelines for Conducting Successful Meetings

Regular meetings of the full membership and meetings of committees are major activities for most advisory boards. Therefore, it is important to be well organized and goal-directed to make the best use of members' time. The following are suggestions to facilitate productive meetings.

Effective School Health Advisory Board Meetings

Tips for effective meetings:

- Develop/provide the agenda in advance
- Begin and end on time
- Stick to the agenda
- Focus the discussion on agenda items
- Maintain an atmosphere that encourages participation
- Summarize periodically
- Maintain a written record of ideas and decisions
- Identify tasks to be completed
- Confirm individual responsibilities
- Consider agenda items for the next meeting

Regular Meeting Schedule: Establish an annual calendar of dates, times, and locations for regular meetings. Some school health advisory boards in geographically large school divisions may alternate locations to distribute travel time for members. Any responsibility for food costs and transportation should be clarified at the beginning of each year. Maps and parking permits should be mailed to members in advance of meetings.

Agenda: Approximately two to three weeks before the meeting send members a tentative agenda with a request for other topics. Prepare the agenda so members

easily understand it (e.g., separate action items on the agenda from information items and discussion-only items). Minutes of the previous meeting should accompany the mailed tentative agenda.

E-mail and Phone Communications: Communicate with each member a few days prior to the meeting as a reminder. Group e-mail lists and establishing a phone tree can promote efficient communication on activities and for inclement weather decisions.

Refreshments: Provide light refreshments if the meeting is not at mealtime. Also indicate a planned amount of time (15 minutes) for networking as part of the agenda.

Punctuality: Start and end the meeting on time. Avoid the tendency of waiting for others and allowing the discussion to drift past a specific time.

Environment and Atmosphere: Hold the meeting in a physically comfortable room that allows members to see and hear each other without difficulty. Stick to the agenda, involve all members, and positively acknowledge all contributions. Encourage discussion and periodically summarize discussions for the group. Keep a written record of discussion topics, major ideas, and decisions (for the minutes).

Follow-up: Assign tasks. Allocate 10-15 minutes at the end of the meeting to determine the tentative agenda for the next meeting.

General Considerations: The agenda for each regular meeting could have the same structure. For example, an agenda may include a set amount of time for socializing, reviewing, and acceptance of the minutes of the last meeting, hearing reports from school personnel on a program or activity, discussing a potential project, reviewing and voting on an issue discussed at the last meeting, etc.

Developing a Strategic Plan

The planning process for either long-range or short-range goals can be a unifying and gratifying experience. The planning process may even be as beneficial to the school community as the actual product that comes out of the effort.

For any planning process, there are several things board members, and especially school health advisory board leaders, need to consider. The first is that *planning is a continuing process* of developing goals, objectives, or strategies/action steps; putting actions into motion, monitoring progress toward accomplishing the board's vision, and then adjusting the goals, objectives, or action steps to address issues at a different level or even focus on new issues. A second consideration for school health advisory board members is that

every member of the diverse board is an equal member of the planning process (students as well as adults). Each member must be free to dream, question, and speculate about possibilities. A third consideration is to embrace change, even when the tendency is to do things as they were done in the past. Following the same old habits of action can lead to paradigm paralysis rather than moving toward constructive progress.

Having a vision or mission statement, or both, helps to guide actions of the board and attract others in the community to the board cause(s). Following are definitions and sets of questions to guide the school health advisory board process in developing a board's vision or mission statement. The responses bring forth valuable information for creating the final statements.

A **vision statement** includes a vivid description of the group as it effectively carries out its operations. The vision defines the board's desires and commitments. Drafting, discussing and agreeing on a vision improves the likelihood that the board's work will be understood and supported (Shirer, 2003).

Generating a Vision for the School Health Advisory Board

- What three things do we like best about our community?
- If you could change one thing about the community, what would it be?
- What concerns you most about students in our school division and their lives now?
- What is one wish that you have for the school division's students?
- What can the school health advisory board do to make this school division a better place to live and learn?
- What can our community agencies and other organizations do to make this school community a better place to live and learn?
- What can families do to make this school community a better place to live and learn?
- Write three hopes for the students and their families living within community.
- In three to four sentences, describe the role of the school health advisory board in helping students grow up healthy, safe, happy, and successful.

Adapted from *Promoting Healthy Youth, Schools, and Communities: A Guide to Community-School Health Councils* (2003). American Cancer Society, Atlanta, GA.

A **mission statement** should be a one-sentence, clear, concise statement that says who the group is, what it does, for whom and where. In essence, it describes the overall purpose of the organization. It is a simple, easy to remember and repeat statement that members can use effectively to lobby on behalf of students and staff. The brief statement can express the uniqueness of the school health advisory board while it describes the commitment of the group's resources to one purpose.

Generating A Mission for the School Health Advisory Board

- What are things that our school health advisory board can be but should not be?
- What is our dream of what the school health advisory board can and should be?
- In very general terms, what will our school health advisory board do?
- How will the school health advisory board do the things listed (named, or described) above?

Next, draft a Mission Statement: It is the Mission of the _____ School Health Advisory Board to (What will be done?) _____ by (or through) _____ (What action? How will it be done?).

Adapted from *The Board Team Planning Manual: A Compete Guide to Long-Range Planning for the Board Team* (1997). Cain Consulting Group.

To move the school health advisory board forward, it is important to examine periodically the group's philosophical basis. Revising a vision or mission statement may help to do this. When refining the mission or vision statement, a useful exercise is to add or delete a word from the mission to realize the change in scope of the mission statement and assess how concise is its wording. Does the mission statement include sufficient description that the statement clearly separates the mission of the group from other groups? Using self-evaluation tools is also a useful activity. The School Health Advisory Board annual report (Appendix C) submitted to the Virginia Department of Education can be used as an evaluation tool to assess goals set and met from the previous year. Similarly, Appendices D and E offer examples of evaluations and worksheets that some school health advisory boards have used to develop or revise their plan of action to meet the health needs of children and youth in their school divisions.

School health advisory boards also need to look at the strengths and weaknesses of the school division by reviewing data on student health, student health-risk behaviors, school

staff well-being, factors that make up quality coordinated school health program components, and community assessments. In communities where some of these data do not exist, school health advisory boards can work with the school division and the community to collect such data (using instruments such as, *Youth Risk Behavior Surveillance Survey*, Division of Adolescent and School Health, Centers for Disease Control and Prevention and *A Model Survey—Healthy Schools Make Sense: Evaluation Your School Health Program*, Virginia Department of Education). Data from these tools can provide concrete information about student health and program strengths and weaknesses within the school community. See section on "Data to Support your School Health Advisory Board."

After reviewing the data and before starting the real planning process, the school health advisory board members can brainstorm the opportunities for change within the school division. The group also will want to examine potential barriers to making specific changes. What impact will the change have on how the community will view the school division? This self-examination allows the group to look at realistic ways they might work toward its written vision or mission statement.

STRATEGIES FOR STRENGTHENING A SCHOOL HEALTH ADVISORY BOARD

Enhancing Activities of a School Health Advisory Board

To enhance or strengthen the work of the school health advisory board, members may want to re-examine their group's processes and actions:

- Review any established or new school division procedures or regulations that may be used by the school health advisory board.

- Establish and periodically review operating procedures/bylaws and objectives and activities of the school health advisory board.

- Orient new members in the components of the coordinated school health program model and elements of comprehensive school health instruction.

- Review activities of other advisory boards and develop a network with those board members.

- Identify obstacles in the community and school division to accomplishing school health advisory board initiatives.

- Conduct ongoing needs assessments, such as (1) reviewing results from a local youth health risk behavior survey of high school or middle school students; (2) a program assessment using *A Model Survey—Healthy Schools Make Sense: Evaluating Your School Health Program* (published by the Virginia Department of Education) that may be downloaded from the Virginia Comprehensive Health Education Training and Resource Center Web site (www.longwood.edu/vchetrc/Data%20and%20Publications.htm); or (3) Data from other community sources (i.e., department of health, community services boards, social services, American Cancer Society, American Heart Association, juvenile justice) may be helpful for local needs assessment (see "Data to Support a SHAB" in this document).

- Establish a mechanism for regular reporting to the school division, individual schools, local school board, and the community on the work of the school health advisory board.

Technical Assistance for a School Health Advisory Board

To ensure consistency over the years in operations of school health advisory boards, the Virginia Department of Education and Virginia Department of Health provide ongoing technical assistance and training sessions for individual school divisions on an "*as requested"* basis.

Funding for these training sessions and workshops is primarily through federal funds to the Department of Education from the Centers for Disease Control and Prevention, Division of Adolescent and School Health. This federal support of state programming has helped to provide consistency in training school health advisory board members, school board members, parents, and specific school personnel in strategies for strengthening the work of school health advisory boards.

Data to Support School Health Advisory Board Activities

Data related to conditions and circumstances that affect the learning environment for all students is a valuable tool for school health advisory boards. Data may enable a division to identify in measurable terms the areas of greatest need (both geographically and behaviorally) in order to focus its efforts on achieving specific outcomes. Data may also be helpful by focusing efforts on achieving specific outcomes, giving a basis for developing and implementing strategies, and providing a baseline for evaluating the effectiveness of a program or activity (Department of Health and Human Services, 2003). A list of selected data resources follows:

VIRGINIA DATA

HEALTH
Division of HIV/STD, Virginia Department of Health, Division of HIV/STD Surveillance Quarterly Reports, Annual Reports and the HIV Epidemiologic Profile of Virginia: www.vdh.state.va.us/std/datahome2.asp
Virginia Department of Health's Health Statistics/Statistical Reports and Tables, at www.vdh.state.va.us/healthstats/stats.asp
Center for Disease Control's Adolescent and School Health (state-specific data available) at www.cdc.gov/nccdphp/dash/

VIOLENCE
Office of Juvenile Justice and Delinquency Prevention Fact Sheets and Bulletins at www.ojjdp.ncjrs.org/index.html
Virginia Department of Health's Center for Injury and Violence Prevention information at www.vahealth.org/civp/preventsuicideva/stats.htm
MULTIPLE TOPICS
The Annie E. Casey Foundation Kid's Count Data (state-specific data available) at www.aecf.org/kidscount/databook/
US Census Bureau at www.census.gov/ (state-specific data available)
Virginia Department of Education Data and Reports (e.g., data on school census, graduates, nutrition, discipline, crime and violence, special education, etc.) at www.pen.k12.va.us/VDOE/Publications
SUBSTANCE ABUSE
Department of Mental Health, Mental Retardation, and Substance Abuse Services at www.dmhmrsas.state.va.us/Organ/CO/Offices/OSAS/RE/SI2002/defaultSI.htm Centers for the Application of Prevention Technologies at www.captus.org/
Governor's Office on Substance Abuse Prevention at www.gosap.state.va.us/professionals.htm
National Institute on Alcohol Abuse and Alcoholism (NIAAA) at www.niaaa.nih.gov
Prevention Online (PrevLine) at www.health.org/

Southeast Centers for the Application of Prevention Technologies (Capt) at www.secapt.org/

NATIONAL DATA

HEALTH
2010 Healthy People Objectives at www.healthypeople.gov/
Office of the Surgeon General's *Call to Action to Prevent Overweight and Obesity* at www.surgeongeneral.gov/topics/obesity/default.htm
VIOLENCE
Partnership Against Violence Network at pavnet.org
MULTIPLE TOPICS
Guide to Community Prevention Services at www.thecommunityguide.org/
United States Department of Health and Human Services at www.hhs.gov/ (type in 'survey' in search box)
National Clearing House on Families and Youth at www.ncfy.com (type in 'survey' or 'data' in search box)
SUBSTANCE ABUSE
Center for Disease Control (Tobacco) at www.cdc.gov/tobacco

Center for Substance Abuse Prevention (CSAP) at
www.samhsa.gov/centers/csap/csap.html

Note: Additional resources can be found in *Tools for Schools to Prevent Chronic Diseases* in Appendix H.

SCHOOL HEALTH, POLICY, LAWS AND REGULATIONS

Ensuring a Match Between State Laws and Local Policy

In Virginia, concern for the health of students has led to a variety of actions over the past fifteen years by the General Assembly and the Board of Education. Actions from the General Assembly commonly requested services (e.g., policies, trainings, guidelines, etc.) through the Secretary of Education, Secretary of Health and Human Resources, or Board of Education to develop and manage specific programs or services, or to develop certain products addressing a wide variety of physical, social, and emotional aspects of child and adolescent health. Action by the Board of Education flows through the Department of Education to the local school divisions.

School health advisory boards need to be aware of certain laws, regulations, and documents that can support work at the local level. For example, the document *Regulations Establishing Standards For Accrediting Public Schools In Virginia* (available at www.pen.k12.va.us/VDOE/Accountability/soafulltxt.pdf) provides information to schools on the required program of instruction at the elementary, middle school, and secondary levels.

At each level is a health-related requirement for school offerings (pages 13-15):

> **Instructional program in elementary schools (8 VAC 20-131-80):** The elementary school "…shall provide instruction in art, music, and physical education and health, and shall provide students with a daily recess during the regular school year as determined appropriate by the school."
>
> **Instructional program in middle schools (8 VAC 20-131-90):** The middle school "…shall provide instruction in art, music, foreign language, physical education and health, and career and technical exploration. The middle school shall provide a minimum of eight courses to students in the eighth grade. Courses in English, mathematics, science, and history/social science shall be required. Four elective courses shall be available: level one of a foreign language, one in health and physical education, one in fine arts, and one in career and technical exploration."
>
> **Instruction program in secondary schools (8 VAC 20-131-100):** "Minimum course offerings for each secondary school shall provide opportunities for students to meet the graduation requirements stated in 8 VAC 20-131-50 and must include:

English	4 Units
Mathematics	4 Units
Science (Laboratory)	4 Units
History and Social Sciences	4 Units
Foreign Language	3 Units
Electives	4 Units
Career and Technical Education	11 Units
Fine Arts	2 Units
Health and Physical Education	2 Units
Total	38 Units

> "Classroom driver education may count for 36 class period of health education. Students shall not be removed from classes other than health and physical education for the in-car phase of driver education."

Included in Appendix B of this publication are copies of the full text of many laws that school health advisory boards need to know about and consider for increasing their background knowledge, group priority setting, and action planning. Descriptions and summaries of other health-related topics in the *Code of Virginia* can be found in *Virginia School Health Guidelines*, published by the Virginia Department of Health, Division of Child and Adolescent Health in collaboration with the Virginia Department of Education (Go to: www.pen.k12.va.us/VDOE/Instruction/Health/home.html). These laws, regulations, and documents demonstrate the emphasis that governmental entities place on the health and well-being of Virginia's children and youth.

Reporting to the Department of Education

- In compliance with § 22.1-275.1 of the *Code of Virginia*, two copies of an annual report form (see Appendix C) must be sent to the Virginia Department of Education.
- Reports should be either **mailed** to Muriel Azria-Evans, comprehensive school health specialist, Virginia Department of Education, P.O. Box 2120, Richmond, VA 23218 or **faxed** to (804) 371-8796 or **emailed** to mazria-e@mail.vak12ed.edu.
- The Department of Education is responsible for sharing the second copy of the report with the Virginia Department of Health.
- Word and PDF versions of the annual report form can be found at www.pen.k12.va.us/VDOE/studentsrvcs/shab.shtml.

A COORDINATED SCHOOL HEALTH PROGRAM

History of Coordinated School Health: Bridging Health and Academic Achievement

Health programs were launched as part of the nation's schools programs at the turn of the 20th century when it was widely recognized that poor sanitation and infectious diseases severely impacted student learning. Even with this recognition, school-based health programs over the century experienced ebbs and flows. During crisis situations, health programs were funded to resolve critical issues (poor dental hygiene, physically unfit Americans, undernourished youth) and make positive changes. Although many considered health programs as supportive of student learning, others in key decision-making positions tightened health programs budgets as the critical health issues subsided.

The focus of school health programming for the last two decades has been to move away from the crisis-centered approach to a health-risk prevention model. Only through this model can school health programs successfully serve the needs of the whole child and help prepare students for productive learning. Nearly 80 national health, education, medical, and youth-serving organizations have published documents or made public statements supporting this concept. The following are samples of some of these statements.

"School health programs offer the opportunity for us to provide the services and knowledge necessary to enable children to be productive learners and to develop the skills to make health decisions needed for the rest of their lives." National School Boards Association, et al., 1995

"Healthy kids make better students. Better students make healthy communities." Council of Chief State School Officers, Association of State & Territorial Health Officials, 2003

"Increasing the educational attainment of every child—leaving no child behind—is one of our nation's highest priorities. Those with the responsibility for improving academic outcomes recognize that, unless educational institutions address the health-related needs that compromise students' ability to learn, students cannot reach their potential as sound, productive citizens." Lloyd Kolbe, *Stories from the Field: Lessons Learned about Building Coordinated School Health Programs*, 2003

The following is a literature review of research studies on the effect of coordinated school health programs on student achievement and success in schools conducted by the Society of State Directors for Health, Physical Education and Recreation and the Association of State and Territorial Health Officials. It also includes support for coordinated school health program as identified in *Health is Academic* (Marx, et al., 1998) and Hanson and Austin (2002).

Data to Support Components of School Health Advisory Programs

Family and Community Involvement in Schools

When parents are involved in their student's education, students show:

- Higher grades and test scores
- Better attendance
- More consistently completed homework (Henderson, 1987)

Community activities that link to the classroom:

- Positively impact academic achievement
- Reduce school suspension rates
- Improve school-related behaviors (Allen, Philliber, Herring, & Kupermine, 1997; Nettles, 1991)

School Nutrition Services

School breakfast programs:

- Increase learning and academic achievement (Hanson & Austin, 2002)
- Improve student attention to academic tasks
- Reduce visits to the school nurse
- Decrease behavior problems (Murphy, Pagano, Nachmani, Sperling, Kane, & Kleinman, 1998)

School breakfast programs positively impact academic performance, absenteeism, and tardiness among high-risk elementary school children living in poverty (Meyers, Sampson, Weitzman, Rogers, & Kayne, 1989)

Data to Support Components of School Health Advisory Programs

Comprehensive School Health Education

Students who participate in health education classes:

- Increase their health knowledge, skills, and practices (e.g., Eccecart et al., 1991)
- Decrease risky behaviors that hinder student learning such as, use of tobacco, alcohol, and other drugs; sexual behaviors that lead to teen pregnancy and sexually transmitted diseases; and more (www.cdc.gov/nccdphp)

The reading and math scores of third and fourth grade students who received comprehensive health education were significantly higher than those third and fourth grade students who had not received comprehensive health education. (Schoener, Guerrero, & Whitney, 1988)

82% of parents from a nationally representative sample felt that health education is either more important or as important as other subjects taught in school. (American Cancer Society, 1994)

School Counseling, Psychological, and Social Services

A comprehensive intervention combining teacher training, parent education, and social competency training in children had long- term positive impacts including:

- Enhanced greater commitment and attachment to school
- Less school misbehavior
- Better academic achievement (Hawkins, Catalano, Kosterman, Abbott, & Hill, 1999)

A school-based social services program targeting students at risk for dropping out of school produced the following results:

- Grade point average (GPA) increased across all classes taken
- Bonding between students in school increased
- Self-esteem improved (Eggert, Thompson, Herting, Nicholas, & Dicker, 1994)

Students who had received a two-year social decision-making and problem-solving program in elementary school showed more pro-social behavior and less antisocial and self-destructive behaviors… when followed up in high school four to six years later. (Elias, Gara, Schuyler, Branden-Muller, & Sayette, 1991)

Data to Support Components of School Health Advisory Programs

Physical Education

Physical activity among adolescents is consistently related to higher levels of self-esteem and lower levels of anxiety and stress (Calfas & Taylor, 1994).

Physical activity is positively associated with academic performance (e.g., Dwyer, Blizzard, & Dean, 1996).

Schools that offered physical education programs did not experience a harmful effect on standardized test scores, though less time was available for other academic subjects (Sallis, McKenzie, Kolody, Lewis, Marshall, & Rosengard, 1999).

Healthy School Environment

Academic achievement has been found to be related to student's perception of school safety (Hanson & Austin, 2002)

An improvement in the school's condition by one category, say from poor to fair, is associated with a 5.5 point improvement in average achievement scores (Berner, 1993).

Students who develop a positive affiliation or social bonding with school are:

- More likely to remain academically engaged (Hanson & Austin, 2002)
- Less likely to be involved with misconduct at school (Simons-Morton, Crump, Haynie, & Saylor, 1999)

School Health Services

Schools with school-based health centers report:

- Increased school attendance
- Decreased drop-outs and suspensions
- Fewer teen pregnancies
- Higher graduation rates (McCord, Klein, Foy, & Fothergill, 1993; Walters, 1996)

Early intervention may improve high school completion rates and lower juvenile crime (Reynolds, Temple, Robertson, & Mann, 2001)

Health services benefit children and youth by

- Reducing barriers to learning and enhancing students' learning potential (Institute of Medicine, 1997)
- Assisting in keeping them safe from major injuries caused by hazards or violence (Education Commission of the States, 1996)
- Providing needed nutrition and mental health, substance abuse, sexual abuse and other counseling services (Knitzer, Steinberger, & Fleisch, 1990)

School-site Health Promotion for Staff

Participants who attended 25 state Health Promotion conferences revealed that participation led to statistically significant changes in use of alcohol, tobacco, and other substances as well as in safety, nutrition, and exercise behaviors (Drolet & Fetro, 1993).

Worksite health promotion programs result in

- Lower medical-claims costs (Fries, Harrington, Edwards, Kent, & Richardson, 1994)
- Greater stress management (Pruitt, Bernheim, & Tomlinson, 1991)

Students benefit from having healthy teachers because:

- Teachers are more energetic
- Teachers are absent less
- The school climate is more optimistic (Symons, Cummings, & Olds, 1994)

Coordinated School Health Programs Today

All members of the school health advisory board should be familiar with the eight components of a coordinated school health program. Prior to the mid-1980s, comprehensive school health programs generally consisted of three components: health instruction, health services, and healthy school environment. Following a groundbreaking article by Diane Allensworth and Lloyd Kolbe in 1987, the concept of school health programming changed dramatically to focus more on needs of the whole child. To implement a comprehensive school health program, schools were challenged to incorporate school nutrition services; counseling, psychological, and social services; physical education; health promotion for staff; and family and community involvement into their program planning.

The concept was further expanded in the late 1990s, more than 70 national health and education organizations convened to develop a plan for writing the book *Health is Academic: A Guide to Coordinated School Health Programs* (1998). Over a two-year period, selected authors wrote chapters describing components of coordinated school health programs, strategies through which staff members working within each component could collaborate, and a systematic approach by which schools and communities can ensure that emotional, mental, physical, and social problems are not barriers to student success in school. These activities resulted in the 1998 publication of the book *Health is Academic: A Guide to Coordinated School Health Programs*, edited by Eva Marx, Susan Wooley, and Daphne Northrop. This text was the first to introduce the term "coordinated school health program" and it further defined actions and interconnection of the varied school programs and services.

In subsequent years, many school divisions, large and small, found ways to apply the broadened concept of school health programming to their school division. A recent publication *Stories from the Field: Lessons Learned about Building Coordinated School Health Programs* (2003; published by the Department of Health and Human Services; Centers for Disease Control and Prevention, Division of Adolescent and School Health) reveals innovative ways nine diverse school districts across the country combined federal, state, and local funds to build programs and make systemic change that met the health needs of their communities. To order a free copy of the book: (1) Send an e-mail request to Division of Adolescent and School Health (DASH) at HealthyYouth@cdc.gov; (2) visit the DASH Web site at http://www.cdc.gov/nccdphp/dash/publications/stories.htm; or (3) call 1-888-231-6405.

A coordinated school health program (CSHP) is defined as a model that is clear, practical approach to promoting the health and well-being of students so that physical, emotional, and social problems do not interfere with student functioning and students can learn to practice healthy behaviors and become productive citizens (Department of Health and

Human Services, 2003). Following are brief descriptions of the eight components of a CSHP:

Family and Community Involvement: Family and community involvement in school health refers to partnerships among schools, families, community groups, and individuals. These partnerships are designed to share and maximize resources and expertise in addressing the healthy development of children, youth, and their families. School health advisory boards should actively solicit parental involvement and engage community resources and services to respond more effectively to the health-related needs of students.

Health Education: This is a planned, sequential, K-12 curriculum that addresses the physical, mental, emotional and social dimensions of health. The curriculum is designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors. It allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skill, and practices. The curriculum is comprehensive and includes a variety of topics such as: personal health, family health, community health, consumer health, environmental health, family life, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, and substance use and abuse.

Physical Education: This is a planned, sequential K-12 curriculum that provides cognitive content and learning experiences in a variety of activity areas such as: basic movement skills; physical fitness; rhythms and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics. Quality physical education should promote, through a variety of planned physical activities, each student's optimum physical, mental, emotional, and social development, and should promote activities and sports that all students enjoy and can pursue throughout their lives.

School Health Services: These services appraise, protect, and promote student health to insure access and/or referral to primary health care services, foster appropriate use of primary health care services, prevent and control emergency care for illness or injury, promote and provide optimum sanitary conditions for a safe school facility and school environment, and provide educational and counseling opportunities for the promotion and maintenance of individual, family, and community health. The following professionals provide such services: physicians, nurses, dentists, health educators, and other allied health personnel.

School-site Health Promotion for Staff: These programs for school staff may provide health assessments, health education, and health-related fitness activities. Such programs encourage and motivate school staff members to pursue a healthy lifestyle, thus promoting better health, improved morale, and a greater personal commitment to the school's overall coordinated school health program. This personal commitment may transfer into greater commitment to the health of students and create positive role remodeling. Health promotion programs can improve productivity, decrease absenteeism, and reduce health insurance cost.

School Nutrition Services: School nutrition services promote the health and education of students through access to a variety of nutritious and appealing meals. Programs respond to the health and nutrition needs of all students. School nutrition programs reflect the U.S. Dietary Guidelines for Americans and other quality criteria to achieve nutrition integrity. The school nutrition programs offer opportunities for students to experience a learning laboratory for classroom nutrition and health education, and serve as a resource for linkages with nutrition-related community services.

School Counseling, Psychological, and Social Services: These services provide broad-based individual and group assessments, interventions, and referrals that attend to the mental, emotional, and social health of students. Organizational assessment and consultation skills of counselors and psychologists contribute to the overall health of students and the health of the school environment. The following professionals provide such services: trained/certified school counselors, psychologists, and social workers.

Healthy School Environment: This component includes the physical and aesthetic surroundings, psycho-social climate, and culture in a school that maximizes the health of students and staff members. Factors that influence the physical environment include the school building and the surrounding area, any biological or chemical agents that might be detrimental to health, and physical conditions such as temperature, noise, and lighting. The psychological environment includes the interrelated physical, emotional, and social conditions that affect the well-being and productivity of the students and the staff members such as: physical and psychological safety, positive interpersonal relationships, recognition of the needs and successes of the individual, and support for building self-esteem in students and the staff.

APPENDICES

APPENDIX A
ACKNOWLEDGMENTS

Sincere appreciation is expressed to the following individuals for their support in review, critique, and revision to this document:

Document Editing and Formatting

Fran Anthony Meyer, PhD, CHES

Muriel Azria-Evans, Ph.D., CFLE

HIV/STDs Resources Review Panel

Virginia Comprehensive Health
Education Training and Resource Center
Longwood University

Barbara Arieti, Counselor
Prince Edward County Elementary School

Doris Ashton, Associate Minister
First Baptist Church, Farmville

Claudia Bates, General Supervisor
Charlotte County Public Schools

Pat Caulkins, School Nurse/Family Life Education Teacher
Waynesboro City Public Schools

Audrey Church, Coordinator School Library Media Program
Longwood University Library

Frona Colker, Health Services Supervisor
Henrico County Public Schools

Bonnie Connor-Gray, Health and Physical Education Supervisor
Henrico County Public Schools

Sharon Easter, Health Committee Chair
Virginia Congress of Parents and Teachers

Maurice Finney, Assistant Superintendent
Prince Edward County Public Schools

Tina Fultz, Middle School Health and Physical Education Teacher
Lunenburg County Public Schools

Alison Gibbs, School Social Worker
Charlotte County Public Schools

Charlotte Guynes, Assistant Professor
Health Education, Longwood University

Kasey Kelly
Division of HIV/STD, Virginia Department of Health

Linda Koogler
School Nurse Coordinator,
August County Schools

Chrys Kosarchyn, PhD, CHES
VCHETRC Director, Professor, Health Education,
Longwood University

Doug Leftwich, President
COHORT of Roanoke Valley

Pat Smith, School Nurse Coordinator
Spotsylvania County Public Schools

Appendix B
Virginia Codes Related to Health Issues

How to download Codes of Virginia:

Because the Virginia Codes may have been modified since the release of this publication, it is recommended that the most current version of a code be reviewed. In order to download recent Virginia Codes:

- Go to legis.state.va.us/
- On the right hand column, under LAW, click on 'Code of Virginia'
- Enter search phrase or Code number in box
- Hit submit

§ 2.2-1159. Facilities for persons with physical disabilities in certain buildings; definitions; construction standards; waiver; temporary buildings.

A. For the purposes of this section and § 2.2-110:

"Building" means any building or facility, used by the public, which is constructed in whole or in part or altered by the use of state, county or municipal funds, or the funds of any political subdivision of this Commonwealth. "Building" shall not include public school buildings and facilities, which shall be governed by standards established by the Board of Education pursuant to § 22.1-138.

"Persons with physical disabilities" means persons with:

1. Impairments that, regardless of cause or manifestation, for all practical purposes, confine individuals to wheelchairs;
2. Impairments that cause individuals to walk with difficulty or insecurity;
3. Total blindness or impairments affecting sight to the extent that the individual functioning in public areas is insecure or exposed to dangers;
4. Deafness or hearing handicaps that might make an individual insecure in public areas because he is unable to communicate or hear warning signals;
5. Faulty coordination or palsy from brain, spinal, or peripheral nerve injury; or
6. Those manifestations of the aging processes that significantly reduce mobility, flexibility, coordination and perceptiveness but are not accounted for in the aforementioned categories.

B. The Division shall prescribe standards for the design, construction, and alteration of buildings constructed in whole or in part or altered by the use of state funds, other than school funds, necessary to ensure that persons with physical disabilities will have ready access to, and use of, such buildings.

C. The governing body of a county, city or town or other political subdivision shall prescribe standards for the design, construction and alteration of buildings, not including public school facilities, constructed in whole or in part or altered by the use of the funds of such locality or political subdivision necessary to ensure that persons with physical disabilities will have ready access to, and use of, such buildings. The Division shall consult with the governing bodies upon request.

D. The Division, with respect to standards issued by it, and the governing body of any county, city or town or other political subdivision with respect to standards issued by it may:

1. Modify or waive any such standard, on a case-by-case basis, upon application made by the head of the department, agency or other instrumentality concerned, upon determining that a modification or waiver is clearly necessary; and
2. Conduct necessary surveys and investigations to ensure compliance with such standards.

E. The provisions of this section and § 2.2-1160 shall apply to temporary and emergency construction as well as permanent buildings.

(1970, c. 539, §§ 2.1-109.01, 2.1-109.02, 2.1-109.03, 2.1-109.04, 2.1-109.06, 2.1-109.07; 1972, c. 223; 1977, c. 672, §§ 2.1-514, 2.1-515, 2.1-516, 2.1-517, 2.1-519, 2.1-520, 2.1-521; 1993, c. 226; 2001, c. 844.)

§ 15.2-2801. Statewide regulation of smoking.

A. The Commonwealth or any agency thereof and every locality shall provide reasonable no-smoking areas, considering the nature of the use and the size of the

building, in any building owned or leased by the Commonwealth or any agency thereof or a locality. The provisions of this chapter shall not apply to office, work or other areas of the Department of Corrections which are not entered by the general public in the normal course of business or use of the premises.

B. Smoking shall be prohibited in (i) elevators, regardless of capacity, except in any open material hoist elevator, not intended for use by the public; (ii) public school buses; (iii) the interior of any public elementary, intermediate, and secondary school; (iv) hospital emergency rooms; (v) local or district health departments; (vi) polling rooms; (vii) indoor service lines and cashier lines; (viii) public restrooms in any building owned or leased by the Commonwealth or any agency thereof; (ix) the interior of a child day center licensed pursuant to § 63.2-1701 that is not also used for residential purposes; however, this prohibition shall not apply to any area of a building not utilized by a child day center, unless otherwise prohibited by this chapter; and (x) public restrooms of health care facilities.

C. Any restaurant having a seating capacity of fifty or more persons shall have a designated no-smoking area sufficient to meet customer demand. In determining the extent of the no-smoking area, the following shall not be included as seating capacity: (i) seats in any bar or lounge area of a restaurant and (ii) seats in any separate room or section of a restaurant which is used exclusively for private functions.

D. The proprietor or other person in charge of an educational facility, except any public elementary, intermediate, or secondary school, health care facility, or a retail establishment of 15,000 square feet or more serving the general public, including, but not limited to, department stores, grocery stores, drug stores, clothing stores, shoe stores, and recreational facilities shall designate reasonable no-smoking areas, considering the nature of the use and the size of the building.

E. The proprietor or other person in charge of a space subject to the provisions of this chapter shall post signs conspicuous to public view stating "Smoking Permitted" or "No Smoking," and in restaurants, signs conspicuous to ordinary public view at or near each public entrance stating "No-Smoking Section Available." Any person failing to post such signs may be subject to a civil penalty of not more than twenty-five dollars.

F. No person shall smoke in a designated no-smoking area and any person who continues to smoke in such area after having been asked to refrain from smoking may be subject to a civil penalty of not more than twenty-five dollars.

G. Any law-enforcement officer may issue a summons regarding a violation of this chapter.

H. The provisions of this chapter shall not be construed to regulate smoking in retail tobacco stores, tobacco warehouses or tobacco manufacturing facilities.

(1990, cc. 902, 969, § 15.1-291.2; 1991, c. 601; 1992, c. 827; 1994, cc. 629, 928; 1996, cc. 472, 514, 778; 1997, c. 587; 2002, c. 283.)

§ 22.1-17.2. Nursing education programs.

The Board of Education and the Board of Nursing, or their representatives, shall, at least annually, develop and revise an interagency agreement relating to the regulation of public school nursing education programs. This memorandum of understanding shall establish a framework

for cooperation in order to achieve consistency in the regulation of such programs. The duties and responsibilities of the Department of Education and the Board of Nursing for public school practical nursing and nurse aide education programs shall be set forth in the agreement. The agreement shall include, but need not be limited to, core curricula for the programs; administrative and clerical activities such as exchange of mailing labels, participation in site visits, reporting requirements, and information for newsletters; review and revision of the curricula materials; participation in inservice activities and state conferences; opportunity to participate in and comment on revisions of any relevant regulations; and communication procedures between the two state agencies and with the local school divisions.
(1991, c. 629.)

§ 22.1-138. Minimum standards for public school buildings.

A. The Board of Education shall prescribe by regulation minimum standards for the erection of or addition to public school buildings governing instructional, operational, health and maintenance facilities where these are not specifically addressed in the Uniform Statewide Building Code.
B. By July 1, 1994, every school building in operation in the Commonwealth shall be tested for radon pursuant to procedures established by the United States Environmental Protection Agency (EPA) for radon measurements in schools. School buildings and additions opened for operation after July 1, 1994, shall be tested for radon pursuant to such EPA procedures and regulations prescribed by the Board of Education pursuant to subsection A of this section. Each school shall maintain files of its radon test results and make such files available for review. The division superintendent shall report radon test results to the Department of Health.
(1980, c. 559; 1993, c. 765.)

§ 22.1-200. Subjects taught in elementary grades.

In the elementary grades of every public school the following subjects shall be taught: Spelling, reading, writing, arithmetic, grammar, geography, health and physical education, drawing, civil government, history of the United States and history of Virginia.
(Code 1950, § 22-233; 1980, c. 559.)

§ 22.1-204. Study of accident prevention.

In one or more of the elementary or secondary grades of every school division there shall be provided a course of study including elementary training in accident prevention, in proper conduct on streets and highways, in the operation of motor vehicles as required by the traffic laws of this Commonwealth, and in ways and means of preventing loss of lives and damage to property through preventable fires. Such course shall be required of every pupil completing the course of study in any such grade.
(Code 1950, § 22-235; 1962, c. 482; 1966, c. 208; 1968, c. 433; 1980, c. 559; 1991, c. 178.)

§ 22.1-205. Driver education programs.

A. The Board of Education shall establish for the public school system a standardized program of driver education in the safe operation of motor vehicles. Such program shall consist of classroom training and behind-the-wheel driver training. However, any student who participates in such a program of driver

education shall meet the academic requirements established by the Board, and no student in a course shall be permitted to operate a motor vehicle without a license or permit to do so issued by the Department of Motor Vehicles. The program shall include instruction concerning (i) alcohol and drug abuse, (ii) aggressive driving, (iii) distracted driving, (iv) motorcycle awareness, and (v) organ and tissue donor awareness. Such instruction shall be developed by the Department in cooperation with the Virginia Alcohol Safety Action Program, the Department of Health, and the Department of Mental Health, Mental Retardation and Substance Abuse Services, as appropriate. Such program shall require a minimum number of miles driven during the behind-the-wheel driver training.

B. The Board shall assist school divisions by preparation, publication and distribution of competent driver education instructional materials to ensure a more complete understanding of the responsibilities and duties of motor vehicle operators.

C. Each school board shall determine whether to offer the program of driver education in the safe operation of motor vehicles and, if offered, whether such program shall be an elective or a required course. Only school divisions complying with the standardized program and regulations established by the Board of Education and the provisions of § 46.2-335 shall be entitled to participate in the distribution of state funds appropriated for driver education.

D. The actual initial driving instruction shall be conducted, with motor vehicles equipped as may be required by regulation of the Board of Education, on private or public property removed from public highways if practicable; if impracticable, then, at the request of the school board, the Commonwealth Transportation Board shall designate a suitable section of road near the school to be used for such instruction. Such section of road shall be marked with signs, which the Commonwealth Transportation Board shall supply, giving notice of its use for driving instruction. Such signs shall be removed at the close of the instruction period. No vehicle other than those used for driver training shall be operated between such signs at a speed in excess of 25 miles per hour. Violation of this limit shall be a Class 4 misdemeanor.

E. The Board of Education may, in its discretion, promulgate regulations for the use and certification of paraprofessionals as teaching assistants in the driver education programs of school divisions.

F. The Board of Education shall approve correspondence courses for the classroom training component of driver education. These correspondence courses shall be consistent in quality with instructional programs developed by the Board for classroom training in the public schools. Students completing the correspondence courses for classroom training, who are eligible to take behind-the-wheel driver training, may receive behind-the-wheel driver training (i) from a public school, upon payment of the required fee, if the school division offers behind-the-wheel driver training and space is available, (ii) from a commercial driver training school licensed by the Department of Motor Vehicles, or (iii) in the case of a home schooling parent or guardian instructing his own child who meets the requirements for home school instruction under § 22.1-254.1 or subdivision B 1 of § 22.1-254, from a behind-the-wheel training course approved by the Board. Nothing herein shall be construed to require any school division to provide behind-the-wheel

driver training to nonpublic school students.
(Code 1950, § 22-235.1; 1962, c. 482; 1966, c. 208; 1968, c. 433; 1974, c. 154; 1980, c. 559; 1988, c. 105; 1989, c. 392; 1998, c. 96; 1999, c. 928; 2000, cc. 82, 651; 2001, cc. 659, 665; 2002, cc. 177, 386; 2003, c. 951.)

§ 22.1-206. Instruction concerning drugs, alcohol, and substance abuse.

A. Instruction concerning drugs and drug abuse shall be provided by the public schools as prescribed by the Board of Education.
B. Instruction concerning the public safety hazards and dangers of alcohol abuse, underage drinking, and drunk driving shall be provided in the public schools. The Department of Alcoholic Beverage Control shall provide educational materials to the Department of Education. The Department of Education shall review and shall distribute such materials as are approved to the public schools.
(Code 1950, § 22-235.1; 1972, c. 248; 1980, c. 559; 2001, c. 452.)

§ 22.1-207. Physical and health education.

Physical and health education shall be emphasized throughout the public school curriculum by lessons, drills and physical exercises, and all pupils in the public elementary, middle, and high schools shall receive as part of the educational program such health instruction and physical training as shall be prescribed by the Board of Education and approved by the State Board of Health.
(Code 1950, § 22-237, 22-243; 1980, c. 559; 1991, c. 178.)

§ 22.1-207.1. Family life education.

The Board of Education shall develop by December 1, 1987, standards of learning and curriculum guidelines for a comprehensive, sequential family life education curriculum in grades K through 12. Such curriculum guidelines shall include instruction as appropriate for the age of the student in family living and community relationships, abstinence education, the value of postponing sexual activity, the benefits of adoption as a positive choice in the event of an unwanted pregnancy, human sexuality, human reproduction, and the etiology, prevention and effects of sexually transmitted diseases.
All such instruction shall be designed to promote parental involvement, foster positive self concepts and provide mechanisms for coping with peer pressure and the stresses of modern living according to the students' developmental stages and abilities. The Board shall also establish requirements for appropriate training for teachers of family life education, which shall include training in instructional elements to support the various curriculum components.
By December 1, 1987, the Board of Education shall provide the House Committee on Appropriations and the Senate Committee on Finance an analysis of the state and local fiscal impact of implementing a mandatory statewide family life education program and a recommended apportionment of state and local funding for such programs if not otherwise determined by law.
For the purposes of this section, "abstinence education" means an educational or motivational component which has as its exclusive purpose teaching the social, psychological, and health gains to be realized by teenagers' abstaining from sexual activity before marriage.

(1987, c. 371; 1999, c. 422; 2002, c. 554.)

§ 22.1-207.2. Right of parents to review certain materials; summaries distributed on request.

Every parent, guardian or other person in the Commonwealth having control or charge of any child who is required by § 22.1-254 A to send such child to a public school shall have the right to review the complete family life curricula, including all supplemental materials used in any family life education program. A complete copy of all printed materials and a description of all audio-visual materials shall be kept in the school library or office and made available for review to any parent or guardian during school office hours before and during the school year. The audio-visual materials shall be made available to parents for review, upon request, on the same basis as printed materials are made available.

Each school board shall develop and, when so requested by an individual parent or guardian of a student participating in the family life education program, distribute to that parent or guardian, a summary designed to assist parents in understanding the program implemented in its school division as such program progresses and to encourage parental guidance and involvement in the instruction of the students. Such information shall reflect the curricula of the program as taught in the classroom. (1989, c. 515; 1991, cc. 139, 526.)

§ 22.1-207.3. School breakfast programs.

A. By July 1, 1994, upon the appropriation and authorization of federal funds for the reimbursement of school breakfast programs, each school board shall establish a school breakfast program in any public school in which twenty-five percent or more of enrolled school-age children were approved eligible to receive free or reduced price meals in the federally funded lunch program during the previous school year.

B. The Board of Education shall promulgate regulations for the implementation of the program. Such regulations shall include, but not be limited to, criteria for eligibility and exemptions; a reporting system for the compilation and analysis of information concerning the number and socioeconomic characteristics of participating school-age children; standards for food services; program evaluation; the investigation of complaints; an appeals process; notification of parents and guardians of the availability of the school breakfast program; and provision to teachers, children, and their parents or guardians of nutrition information describing the relationship between good nutrition, learning, and health.

C. Each school board subject to the provisions of this section shall develop and implement a plan to ensure compliance with the provisions of subsection A and submit the plan to the Department of Education no later than thirty days prior to the commencement of the program. Beginning by June 30, 1995, and thereafter annually, each school board shall report such information as required in subsection B to the Department of Education on such forms and in the manner to be prescribed by the Board. In the event that federal funding for school breakfast programs is reduced or eliminated, a school board may support the program with such state or local funds as may be appropriated for such purposes. (1993, c. 698.)

§ 22.1-208. Emphasis on moral education.

The entire scheme of instruction in the public schools shall emphasize moral education through lessons given by teachers and imparted by appropriate reading selections.
(Code 1950, § 22-238; 1980, c. 559.)

§ 22.1-254. Compulsory attendance required; excuses and waivers; alternative education program attendance; exemptions from article.

A. Except as otherwise provided in this article, every parent, guardian, or other person in the Commonwealth having control or charge of any child who will have reached the fifth birthday on or before September 30 of any school year and who has not passed the eighteenth birthday shall, during the period of each year the public schools are in session and for the same number of days and hours per day as the public schools, send such child to a public school or to a private, denominational or parochial school or have such child taught by a tutor or teacher of qualifications prescribed by the Board of Education and approved by the division superintendent or provide for home instruction of such child as described in § 22.1-254.1.
As prescribed in the regulations of the Board of Education, the requirements of this section may also be satisfied by sending a child to an alternative program of study or work/study offered by a public, private, denominational or parochial school or by a public or private degree-granting institution of higher education. Further, in the case of any five-year-old child who is subject to the provisions of this subsection, the requirements of this section may be alternatively satisfied by sending the child to any public educational prekindergarten program, including a Head Start program, or in a private, denominational or parochial educational prekindergarten program.
Instruction in the home of a child or children by the parent, guardian or other person having control or charge of such child or children shall not be classified or defined as a private, denominational or parochial school.
The requirements of this section shall apply to (i) any child in the custody of the Department of Juvenile Justice or the Department of Corrections who has not passed his eighteenth birthday and (ii) any child whom the division superintendent has required to take a special program of prevention, intervention, or remediation as provided in subsection C of §22.1-253.13:1 and in § 22.1-254.01. However, the requirements of this section shall not apply to any child who has obtained a high school diploma, its equivalent, or a certificate of completion or who has otherwise complied with compulsory school attendance requirements as set forth in this article.
B. A school board shall excuse from attendance at school:
1. Any pupil who, together with his parents, by reason of bona fide religious training or belief is conscientiously opposed to attendance at school. For purposes of this subdivision, "bona fide religious training or belief" does not include essentially political, sociological or philosophical views or a merely personal moral code; and
2. On the recommendation of the juvenile and domestic relations district court of the county or city in which the pupil resides and for such period of time as the court deems appropriate, any pupil who, together with his parents, is opposed to attendance at a school by reason of concern for such pupil's health, as verified

by competent medical evidence, or by reason of such pupil's reasonable apprehension for personal safety when such concern or apprehension in that pupil's specific case is determined by the court, upon consideration of the recommendation of the principal and division superintendent, to be justified.

C. A school board may excuse from attendance at school:

1. On recommendation of the principal and the division superintendent and with the written consent of the parent or guardian, any pupil who the school board determines, in accordance with regulations of the Board of Education, cannot benefit from education at such school; and

2. On recommendation of the juvenile and domestic relations district court of the county or city in which the pupil resides, any pupil who, in the judgment of such court, cannot benefit from education at such school.

D. Local school boards may allow the requirements of subsection A of this section to be met under the following conditions:

For a student who is at least 16 years of age, there shall be a meeting of the student, the student's parents, and the principal or his designee of the school in which the student is enrolled in which an individual student alternative education plan shall be developed in conformity with guidelines prescribed by the Board, which plan must include:

a. Career guidance counseling;

b. Mandatory enrollment and attendance in a general educational development preparatory program or other alternative education program approved by the local school board with attendance requirements that provide for reporting of student attendance by the chief administrator of such GED preparatory program or approved alternative education program to such principal or his designee;

c. Counseling on the economic impact of failing to complete high school; and

d. Procedures for reenrollment to comply with the requirements of subsection A of this section.

A student for whom an individual student alternative education plan has been granted pursuant to this subsection and who fails to comply with the conditions of such plan shall be in violation of the compulsory school attendance law, and the division superintendent or attendance officer of the school division in which such student was last enrolled shall seek immediate compliance with the compulsory school attendance law as set forth in this article.

Students enrolled with an individual student alternative education plan shall be counted in the average daily membership of the school division.

E. A school board may, in accordance with the procedures set forth in Article 3 (§ 22.1-276.01 et seq.) of Chapter 14 of this title and upon a finding that a school-age child has been (i) charged with an offense relating to the Commonwealth's laws, or with a violation of school board policies, on weapons, alcohol or drugs, or intentional injury to another person; (ii) found guilty or not innocent of a crime that resulted in or could have resulted in injury to others, or of an offense that is required to be disclosed to the superintendent of the school division pursuant to subsection G of § 16.1-260; (iii) suspended pursuant to § 22.1-277.0; or (iv) expelled from school attendance pursuant to § 22.1-277.06 or § 22.1-277.07 or subsection B of § 22.1-277, require the child to attend an alternative education program as provided in § 22.1-209.1:2 or § 22.1-277.2:1.

F. Whenever a court orders any pupil into an alternative education program offered in the public schools, the local school board of the school division in which the program is offered shall determine the appropriate alternative education placement of the pupil, regardless of whether the pupil attends the public schools it supervises or resides within its school division.

The juvenile and domestic relations district court of the county or city in which a pupil resides or in which charges are pending against a pupil, or any court in which charges are pending against a pupil, may require the pupil who has been charged with (i) a crime which resulted in or could have resulted in injury to others, (ii) a violation of Article 1 (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2, or (iii) any offense related to possession or distribution of any Schedule I, II, or III controlled substances to attend an alternative education program, including, but not limited to, night school, adult education, or any other education program designed to offer instruction to students for whom the regular program of instruction may be inappropriate.

This subsection shall not be construed to limit the authority of school boards to expel, suspend, or exclude students, as provided in §§ 22.1-277.04, 22.1-277.05, 22.1-277.06, 22.1-277.07, and 22.1-277.2.

As used in this subsection, the term "charged" means that a petition or warrant has been filed or is pending against a pupil.

G. Within one calendar month of the opening of school, each school board shall send to the parents or guardian of each student enrolled in the division a copy of the compulsory school attendance law and the enforcement procedures and policies established by the school board.

H. The provisions of this article shall not apply to:

1. Children suffering from contagious or infectious diseases while suffering from such diseases;

2. Children whose immunizations against communicable diseases have not been completed as provided in § 22.1-271.2;

3. Children under 10 years of age who live more than two miles from a public school unless public transportation is provided within one mile of the place where such children live;

4. Children between the ages of 10 and 17, inclusive, who live more than 2.5 miles from a public school unless public transportation is provided within 1.5 miles of the place where such children live; and

5. Children excused pursuant to subsections B and C of this section.

Further, any child who will not have reached his sixth birthday on or before September 30 of each school year whose parent or guardian notifies the appropriate school board that he does not wish the child to attend school until the following year because the child, in the opinion of the parent or guardian, is not mentally, physically or emotionally prepared to attend school, may delay the child's attendance for one year.

The distances specified in subdivisions 3 and 4 of this subsection shall be measured or determined from the child's residence to the entrance to the school grounds or to the school bus stop nearest the entrance to the residence of such children by the nearest practical routes which are usable for walking or riding. Disease shall be established by the certificate of a reputable practicing physician in accordance with regulations adopted by the Board of Education.

(Code 1950, § 22-275.1; 1952, c. 279; 1959, Ex. Sess., c. 72; 1968, c. 178; 1974, c. 199; 1976, cc. 681, 713; 1978, c. 518;

1980, c. 559; 1984, c. 436; 1989, c. 515; 1990, c. 797; 1991, c. 295; 1993, c. 903; 1996, cc. 163, 916, 964; 1997, c. 828; 1999, cc. 488, 552; 2000, c. 184; 2001, cc. 688, 820; 2003, c. 119.)

§ 22.1-271.2. Immunization requirements.

A. No student shall be admitted by a school unless at the time of admission the student or his parent or guardian submits documentary proof of immunization to the admitting official of the school or unless the student is exempted from immunization pursuant to subsection C. If a student does not have documentary proof of immunization, the school shall notify the student or his parent or guardian (i) that it has no documentary proof of immunization for the student; (ii) that it may not admit the student without proof unless the student is exempted pursuant to subsection C; (iii) that the student may be immunized and receive certification by a licensed physician, registered nurse or an employee of a local health department; and (iv) how to contact the local health department to learn where and when it performs these services. Neither this Commonwealth nor any school or admitting official shall be liable in damages to any person for complying with this section.

Any physician, registered nurse or local health department employee performing immunizations shall provide to any person who has been immunized or to his parent or guardian, upon request, documentary proof of immunizations conforming with the requirements of this section.

B. Any student whose immunizations are incomplete may be admitted conditionally if that student provides documentary proof at the time of enrollment of having received at least one dose of the required immunizations accompanied by a schedule for completion of the required doses within ninety days.

The immunization record of each student admitted conditionally shall be reviewed periodically until the required immunizations have been received.

Any student admitted conditionally and who fails to comply with his schedule for completion of the required immunizations shall be excluded from school until his immunizations are resumed.

C. No certificate of immunization shall be required for the admission to school of any student if (i) the student or his parent or guardian submits an affidavit to the admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices; or (ii) the school has written certification from a licensed physician or a local health department that one or more of the required immunizations may be detrimental to the student's health, indicating the specific nature and probable duration of the medical condition or circumstance that contraindicates immunization.

D. The admitting official of a school shall exclude from the school any student for whom he does not have documentary proof of immunization or notice of exemption pursuant to subsection C.

E. Every school shall record each student's immunizations on the school immunization record. The school immunization record shall be a standardized form provided by the State Department of Health, which shall be a part of the mandatory permanent student record. Such record shall be open to inspection by officials of the State Department of Health and the local health departments.

The school immunization record shall be transferred by the school whenever the

school transfers any student's permanent academic or scholastic records.
Within thirty calendar days after the beginning of each school year or entrance of a student, each admitting official shall file a report with the local health department. The report shall be filed on forms prepared by the State Department of Health and shall state the number of students admitted to school with documentary proof of immunization, the number of students who have been admitted with a medical or religious exemption and the number of students who have been conditionally admitted.
F. The requirement for mumps immunization as provided in § 32.1-46 shall not apply to any child admitted for the first time to any grade level, kindergarten through grade twelve, of a school prior to August 1, 1981.
The requirement for Haemophilus Influenzae Type b immunization as provided in § 32.1-46 shall not apply to any child admitted to any grade level, kindergarten through grade twelve.
G. The Board of Health shall promulgate rules and regulations for the implementation of this section in congruence with rules and regulations of the Board of Health promulgated under § 32.1-46 and in cooperation with the Board of Education.
(1982, c. 510; 1983, c. 433; 1988, c. 216; 1989, c. 382; 2000, c. 476.)

§ 22.1-271.3. Guidelines for school attendance for children infected with human immunodeficiency virus; school personnel training required; notification of school personnel in certain cases.

A. The Board of Education, in cooperation with the Board of Health, shall develop, and revise as necessary, model guidelines for school attendance for children infected with human immunodeficiency virus. The first such guidelines shall be completed by December 1, 1989. The Board shall distribute copies of these guidelines to each division superintendent and every school board member in the Commonwealth immediately following completion.
B. Each school board shall, by July 1, 1990, adopt guidelines for school attendance for children with human immunodeficiency virus. Such guidelines shall be consistent with the model guidelines for such school attendance developed by the Board of Education.
C. Every school board shall ensure that all school personnel having direct contact with students receive appropriate training in the etiology, prevention, transmission modes, and effects of blood-borne pathogens, specifically, hepatitis B and human immunodeficiency viruses or any other infections that are the subject of regulations promulgated by the Safety and Health Codes Board of the Virginia Occupational Safety and Health Program within the Department of Labor and Industry.
D. Upon notification by a school employee who believes he has been involved in a possible exposure-prone incident which may have exposed the employee to the blood or body fluids of a student, the division superintendent shall contact the local health director who, upon immediate investigation of the incident, shall determine if a potentially harmful exposure has occurred and make recommendations, based upon all information available to him, regarding how the employee can reduce any risks from such exposure. The division superintendent shall share these recommendations with the school employee. Except as permitted by § 32.1-

45.1, the division superintendent and the school employee shall not divulge any information provided by the local health director regarding such student. The information provided by the local health director shall be subject to any applicable confidentiality requirements set forth in Chapter 2 (§ 32.1-35 et seq.) of Title 32.1. (1989, c. 613; 1997, c. 685; 2003, c. 1.)

§ 22.1-272. Contagious and infectious diseases.

Persons suffering with contagious or infectious disease shall be excluded from the public schools while in that condition. (Code 1950, § 22-249; 1968, c. 445; 1970, c. 526; 1973, c. 491; 1974, c. 160; 1977, c. 220; 1979, c. 262; 1980, c. 559.) **Please refer to Superintendent Memo # 32, 2004 regarding *Model Guidelines for School Attendance for Children with Human Immunodeficiency Virus (HIV)***

§ 22.1-272.1. Responsibility to contact parent of student at imminent risk of suicide; notice to be given to social services if parental abuse or neglect; Board of Education, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Health, to develop guidelines for parental contact.

A. Any person licensed as administrative or instructional personnel by the Board of Education and employed by a local school board who, in the scope of his employment, has reason to believe, as a result of direct communication from a student, that such student is at imminent risk of suicide, shall, as soon as practicable, contact at least one of such student's parents to ask whether such parent is aware of the student's mental state and whether the parent wishes to obtain or has already obtained counseling for such student. Such contact shall be made in accordance with the provisions of the guidelines required by subsection C.

B. If the student has indicated that the reason for being at imminent risk of suicide relates to parental abuse or neglect, this contact shall not be made with the parent. Instead, the person shall, as soon as practicable, notify the local department of social services of the county or city wherein the child resides or wherein the abuse or neglect is believed to have occurred or the state Department of Social Services' toll-free child abuse and neglect hotline, as required by § 63.2-1509. When giving this notice to the local or state department, the person shall stress the need to take immediate action to protect the child from harm.

C. The Board of Education, in cooperation with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Health, shall develop guidelines for making the contact required by subsection A. These guidelines shall include, but need not be limited to, (i) criteria to assess the suicide risks of students, (ii) characteristics to identify potentially suicidal students, (iii) appropriate responses to students expressing suicidal intentions, (iv) available and appropriate community services for students expressing suicidal intentions, (v) suicide prevention strategies which may be implemented by local schools for students expressing suicidal intentions, (vi) criteria for notification of and discussions with parents of students expressing suicidal intentions, (vii) criteria for as-soon-as-practicable contact with the parents, (viii) appropriate sensitivity to religious beliefs, and (ix) legal requirements and criteria for notification of public service agencies, including, but not limited to, the local or state social services and mental health

agencies. These guidelines may include case studies and problem-solving exercises and may be designed as materials for in-service training programs for licensed administrative and instructional personnel.
(1999, c. 425.)

§ 22.1-273. Sight and hearing of pupil to be tested.

The Superintendent of Public Instruction shall prepare or cause to be prepared, with the advice and approval of the State Health Commissioner, suitable test cards, blanks, record books, and other appliances for testing the sight and hearing of the pupils in the public schools and necessary instructions for the use thereof. The State Department of Education shall furnish the same free of expense to all schools in a school division upon request of the school board of such division accompanied by a resolution of the school board directing the use of such test cards, blanks, record books and other appliances in the schools of the school division.
Within the time periods and at the grades provided in regulations promulgated by the Board of Education, the principal of each such school shall cause the sight and hearing of the relevant pupils in the school to be tested, unless such students are pupils admitted for the first time to a public kindergarten or elementary school who have been so tested as part of the comprehensive physical examination required by § 22.1-270 or the parents or guardians of such students object on religious grounds and the students show no obvious evidence of any defect or disease of the eyes or ears. The principal shall keep a record of such examinations in accordance with instructions furnished. Whenever a pupil is found to have any defect of vision or hearing or a disease of the eyes or ears, the principal shall forthwith notify the parent or guardian, in writing, of such defect or disease. Copies of the report shall be preserved for the use of the Superintendent of Public Instruction as he may require.
(Code 1950, § 22-248; 1980, c. 559; 1981, c. 142; 1995, c. 246.)

§ 22.1-274. School health services.
A. A school board shall provide pupil personnel and support services, in compliance with § 22.1-253.13:2. A school board may employ school nurses, physicians, physical therapists, occupational therapists and speech therapists. No such personnel shall be employed unless they meet such standards as may be determined by the Board of Education. Subject to the approval of the appropriate local governing body, a local health department may provide personnel for health services for the school division.
B. In implementing subsection C of § 22.1-253.13:2, relating to providing support services which are necessary for the efficient and cost-effective operation and maintenance of its public schools, each school board may strive to employ, or contract with local health departments for, nursing services consistent with a ratio of at least one nurse (i) per 2,500 students by July 1, 1996; (ii) per 2,000 students by July 1, 1997; (iii) per 1,500 students by July 1, 1998; and (iv) per 1,000 students by July 1, 1999. In those school divisions in which there are more than 1,000 students in average daily membership in school buildings, this section shall not be construed to encourage the employment of more than one nurse per school building. Further, this section shall not be construed to mandate the aspired-to ratios.
C. The Board of Education shall monitor the progress in achieving the ratios set forth in subsection B of this section and

any subsequent increase in prevailing statewide costs, and the mechanism for funding health services, pursuant to subsection E of § 22.1-253.13:2 and the appropriation act. The Board shall also determine how school health funds are used and school health services are delivered in each locality and shall provide, by December 1, 1994, a detailed analysis of school health expenditures to the House Committee on Education, the House Committee on Appropriations, the Senate Committee on Education and Health, and the Senate Committee on Finance.

D. With the exception of school administrative personnel and persons employed by school boards who have the specific duty to deliver health-related services, no licensed instructional employee, instructional aide, or clerical employee shall be disciplined, placed on probation or dismissed on the basis of such employee's refusal to (i) perform nonemergency health-related services for students or (ii) obtain training in the administration of insulin and glucagon. However, instructional aides and clerical employees may not refuse to dispense oral medications.

For the purposes of this subsection, "health-related services" means those activities which, when performed in a health care facility, must be delivered by or under the supervision of a licensed or certified professional.

E. Each school board shall ensure that, in school buildings with an instructional and administrative staff of ten or more, (i) at least two employees have current certification in cardiopulmonary resuscitation or have received training, within the last two years, in emergency first aid and cardiopulmonary resuscitation and (ii) if one or more students diagnosed as having diabetes attend such school, at least two employees have been trained in the administration of insulin and glucagon. In school buildings with an instructional and administrative staff of fewer than ten, school boards shall ensure that (i) at least one employee has current certification in cardiopulmonary resuscitation or has received training, within the last two years, in emergency first aid and cardiopulmonary resuscitation and (ii) if one or more students diagnosed as having diabetes attend such school, at least one employee has been trained in the administration of insulin and glucagon. "Employee" shall include any person employed by a local health department who is assigned to the public school pursuant to an agreement between the local health department and the school board. When a registered nurse, nurse practitioner, physician or physician assistant is present, no employee who is not a registered nurse, nurse practitioner, physician or physician assistant shall assist with the administration of insulin or administer glucagon. Prescriber authorization and parental consent shall be obtained for any employee who is not a registered nurse, nurse practitioner, physician or physician assistant to assist with the administration of insulin and administer glucagon.

(Code 1950, § 22-241; 1956, c. 656; 1980, c. 559; 1990, c. 797; 1991, c. 295; 1994, c. 712; 1997, c. 597; 1998, c. 871; 1999, cc. 570, 757.)

§ 22.1-274.01. School Nurse Incentive Grants Program and Fund.

A. From such funds as may be appropriated for such purpose and from such gifts, donations, grants, bequests, and other funds as may be received on its behalf, there is hereby established the School Nurse Incentive Grants Program, to be administered by the Board of

Education, and a special nonreverting fund within the state treasury known as the School Nurse Incentive Grants Fund, hereinafter known as the "Fund." The Fund shall be established on the books of the Comptroller, and any moneys remaining in such Fund at the end of the biennium shall not revert to the general fund but shall remain in the Fund. Interest earned on such funds shall remain in the Fund and be credited to it.

Subject to the authority of the Board of Education to provide for its disbursement, the Fund shall be disbursed to award matching grants to school boards to employ, or contract with local health departments for, nursing services to achieve the ratio as provided in § 22.1-274.

B. The Board shall establish criteria for making grants from the Fund, including procedures for determining amounts of grants and the required local match, which shall be calculated on the basis of the composite index of local ability to pay. The Board may issue guidelines governing the Program as it deems necessary and appropriate.

(1998, c. 904.)

§ 22.1-274.02. Certain memorandum of agreement required.

A. The Superintendent of Public Instruction or his designee and the Director of the Department of Medical Assistance Services or his designee shall develop and execute a memorandum of agreement relating to special education health services. This memorandum of agreement shall be revised on a periodic basis; however, the agreement shall, at a minimum, be revised and executed within six months of the inauguration of a new governor in order to maintain policy integrity.

B. The agreement shall include, but need not be limited to, (i) requirements for regular and consistent communications and consultations between the two departments and with school division personnel and officials and school board representatives; (ii) a specific and concise description and history of the federal Individuals with Disabilities Education Act (IDEA), a summary of school division responsibilities pursuant to the Individuals with Disabilities Education Act, and a summary of any corresponding state law which influences the scope of these responsibilities; (iii) a specific and concise summary of the then-current Department of Medical Assistance Services regulations regarding the special education health services; (iv) assignment of the specific responsibilities of the two state departments for the operation of special education health services; (v) a schedule of issues to be resolved through the regular and consistent communications process, including, but not limited to, ways to integrate and coordinate care between the Department of Medical Assistance Services' managed care providers and special education health services providers; (vi) a process for the evaluation of the services which may be delivered by school divisions participating as special education health services providers pursuant to Medicaid; (vii) a plan and schedule to reduce the administrative and paperwork burden of Medicaid participation on school divisions in Virginia; and (viii) a mechanism for informing primary care providers and other case management providers of those school divisions that are participating as Medicaid providers and for identifying such school divisions as Medicaid providers that are available to receive referrals to provide special education health services.

C. The Board of Education shall cooperate with the Board of Medical Assistance Services in developing a form to be included with the Individualized Education Plan (IEP) that shall be accepted by the Department of Medical Assistance Services as the plan of care (POC) and in collecting the data necessary to establish separate and specific Medicaid rates for the IEP meetings and other services delivered by school divisions to students.

The POC form shall (i) be consistent with the plan of care required by the Department of Medical Assistance Services of other Medicaid providers, (ii) allow for written updates, (iii) be used by all school divisions participating as Medicaid providers of special education health services, (iv) document the student's progress, and (v) be integrated and coordinated with the Department of Medical Assistance Services' managed care providers.

D. The Department of Education shall prepare, upon consultation with the Department of Medical Assistance Services, a consent form which (i) is separate from the IEP, (ii) includes a statement noting that such form is not part of the student's IEP, (iii) includes a release to authorize billing of school-based health services delivered to the relevant student by the school division, and (iv) shall be used by all school divisions participating in Medicaid reimbursement. This consent form shall be made available to the parents upon conclusion of the IEP meeting. The release shall allow for billing of school-based health services by Virginia school divisions to the Virginia Medicaid program and other programs operated by the Department of Medical Assistance Services.

E. The Department of Education and the Department of Medical Assistance Services shall also develop a cost-effective, efficient, and appropriate process to allow school divisions access to eligibility data for students for whom consent has been obtained.

(1999, cc. 967, 1005.)

§ 22.1-274.1. Criteria to identify toxic art materials; labeling; use in certain grades prohibited.

The State Department of Education, in cooperation with the State Department of Health, shall develop criteria to identify toxic art materials.

After these criteria have been developed, the Department of Education shall require school divisions to evaluate all art materials used in schools and identify those which are toxic. All materials used in the public schools which meet the criteria as toxic shall be so labeled and the use of such art materials shall be prohibited in kindergarten through grade five.

(1987, c. 225; 1988, c. 103.)

§ 22.1-274.2. Possession and self-administration of inhaled asthma medications by asthmatic students.

A. Effective on July 1, 2000, local school boards shall develop and implement policies permitting a student with a diagnosis of asthma to possess and self-administer inhaled asthma medications during the school day, at school-sponsored activities, or while on a school bus or other school property. Such policies shall include, but not be limited to, provisions for:

1. Written consent of the parent, as defined in § 22.1-1, of a student with a diagnosis of asthma that the student may self-administer inhaled asthma medications.

2. Written notice from the student's primary care provider or medical

specialist, or a licensed physician or licensed nurse practitioner that (i) identifies the student; (ii) states that the student has a diagnosis of asthma and has approval to self-administer inhaled asthma medications that have been prescribed or authorized for the student; (iii) specifies the name and dosage of the medication, the frequency in which it is to be administered and certain circumstances which may warrant the use of inhaled asthma medications, such as before exercising or engaging in physical activity to prevent the onset of asthmatic symptoms or to alleviate asthmatic symptoms after the onset of an asthmatic episode; and (iv) attests to the student's demonstrated ability to safely and effectively self-administer inhaled asthma medications.

3. Development of an individualized health care plan, including emergency procedures for any life-threatening conditions.

4. Consultation with the student's parent before any limitations or restrictions are imposed upon a student's possession and self-administration of inhaled asthma medications, and before the permission to possess and self-administer inhaled asthma medications at any point during the school year is revoked.

5. Self-administration of inhaled asthma medications to be consistent with the purposes of the Virginia School Health Guidelines and the Guidelines for Specialized Health Care Procedure Manuals, which are jointly issued by the Department of Education and the Department of Health.

6. Disclosure or dissemination of information pertaining to the health condition of a student to school board employees to comply with §§ 22.1-287 and 22.1-289 and the federal Family Education Rights and Privacy Act of 1974, as amended, 20 U.S.C. § 1232g, which govern the disclosure and dissemination of information contained in student scholastic records.

B. The permission granted a student with a diagnosis of asthma to possess and self-administer inhaled asthma medications shall be effective for one school year. Permission to possess and self-administer inhaled asthma medications shall be renewed annually. For the purposes of this section, "one school year" means 365 calendar days.

(2000, c. 871.)

§ 54.1-3408. Professional use by practitioners.

A. A practitioner of medicine, osteopathy, podiatry, dentistry, or veterinary medicine or a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to§ 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 of this title shall only prescribe, dispense, or administer controlled substances in good faith for medicinal or therapeutic purposes within the course of his professional practice.

B. The prescribing practitioner's order may be on a written prescription or pursuant to an oral prescription as authorized by this chapter. The prescriber may administer drugs and devices, or he may cause them to be administered by a nurse, physician assistant or intern under his direction and supervision, or he may prescribe and cause drugs and devices to be administered to patients in state-owned or state-operated hospitals or facilities licensed as hospitals by the Board of Health or psychiatric hospitals licensed by the State Mental Health, Mental Retardation and Substance Abuse Services Board by other persons who have been trained properly to administer drugs

and who administer drugs only under the control and supervision of the prescriber or a pharmacist or a prescriber may cause drugs and devices to be administered to patients by emergency medical services personnel who have been certified and authorized to administer such drugs and devices pursuant to Board of Health regulations governing emergency medical services and who are acting within the scope of such certification. A prescriber may authorize a certified respiratory therapy practitioner as defined in § 54.1-2954 to administer by inhalation controlled substances used in inhalation or respiratory therapy.

C. Pursuant to an oral or written order or standing protocol, the prescriber, who is authorized by state or federal law to possess and administer radiopharmaceuticals in the scope of his practice, may authorize a nuclear medicine technologist to administer, under his supervision, radiopharmaceuticals used in the diagnosis or treatment of disease.

D. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered nurses and licensed practical nurses to possess (i) epinephrine for administration in treatment of emergency medical conditions and (ii) heparin and sterile normal saline to use for the maintenance of intravenous access lines. Pursuant to the regulations of the Board of Health, certain emergency medical services technicians may possess and administer epinephrine in emergency cases of anaphylactic shock.

E. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed physical therapists to possess and administer topical corticosteroids, topical lidocaine, and any other Schedule VI topical drug.

F. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, and in accordance with policies and guidelines established by the Department of Health pursuant to § 32.1-50.2, such prescriber may authorize registered nurses or licensed practical nurses under the immediate and direct supervision of a registered nurse to possess and administer tuberculin purified protein derivative (PPD) in the absence of a prescriber. The Department of Health's policies and guidelines shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention for preventing transmission of mycobacterium tuberculosis and shall be updated to incorporate any subsequently implemented standards of the Occupational Safety and Health Administration and the Department of Labor and Industry to the extent that they are inconsistent with the Department of Health's policies and guidelines. Such standing protocols shall explicitly describe the categories of persons to whom the tuberculin test is to be administered and shall provide for appropriate medical evaluation of those in whom the test is positive. The prescriber shall ensure that the nurse implementing such standing protocols has received adequate training in the practice and principles underlying tuberculin screening.

The Health Commissioner or his designee may authorize registered nurses, acting as agents of the Department of Health, to possess and administer, at the nurse's discretion, tuberculin purified protein derivative (PPD) to those persons in whom tuberculin skin testing is indicated

based on protocols and policies established by the Department of Health.
G. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the parents as defined in § 22.1-1, an employee of a school board who is trained in the administration of insulin and glucagon to assist with the administration of insulin or administer glucagon to a student diagnosed as having diabetes and who requires insulin injections during the school day or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia. Such authorization shall only be effective when a licensed nurse, nurse practitioner, physician or physician assistant is not present to perform the administration of the medication.
H. A prescriber may authorize, pursuant to a protocol approved by the Board of Nursing, the administration of vaccines to adults for immunization, when a practitioner with prescriptive authority is not physically present, (i) by licensed pharmacists, (ii) by registered nurses, or (iii) licensed practical nurses under the immediate and direct supervision of a registered nurse. A prescriber acting on behalf of and in accordance with established protocols of the Department of Health may authorize the administration of vaccines to any person by a pharmacist or nurse when the prescriber is not physically present.
I. A dentist may cause Schedule VI topical drugs to be administered under his direction and supervision by either a dental hygienist or by an authorized agent of the dentist.
Further, pursuant to a written order and in accordance with a standing protocol issued by the dentist in the course of his professional practice, a dentist may authorize a dental hygienist under his general supervision, as defined in § 54.1-2722, to possess and administer topical oral fluorides, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions, as well as any other Schedule VI topical drug approved by the Board of Dentistry.
J. This section shall not prevent the administration of drugs by a person who has satisfactorily completed a training program for this purpose approved by the Board of Nursing and who administers such drugs in accordance with a physician's instructions pertaining to dosage, frequency, and manner of administration, and in accordance with regulations promulgated by the Board of Pharmacy relating to security and record keeping, when the drugs administered would be normally self-administered by (i) a resident of a facility licensed or certified by the State Mental Health, Mental Retardation and Substance Abuse Services Board; (ii) a resident of any assisted living facility which is licensed by the Department of Social Services; (iii) a resident of the Virginia Rehabilitation Center for the Blind and Vision Impaired; (iv) a resident of a facility approved by the Board or Department of Juvenile Justice for the placement of children in need of services or delinquent or alleged delinquent youth; (v) a program participant of an adult day-care center licensed by the Department of Social Services; or (vi) a resident of any facility authorized or operated by a state or local government whose primary purpose is not to provide health care services.
K. In addition, this section shall not prevent the administration of drugs by a person who administers such drugs in accordance with a physician's instructions pertaining to dosage, frequency, and

manner of administration and with written authorization of a parent, and in accordance with school board regulations relating to training, security and record keeping, when the drugs administered would be normally self-administered by a student of a Virginia public school. Training for such persons shall be accomplished through a program approved by the local school boards, in consultation with the local departments of health.

L. In addition, this section shall not prevent the administration or dispensing of drugs and devices by persons if they are authorized by the State Health Commissioner in accordance with protocols established by the State Health Commissioner pursuant to § 32.1-42.1 when (i) the Governor has declared a disaster or a state of emergency caused by an act of terrorism or the United States Secretary of Health and Human Services has issued a declaration of an actual or potential bioterrorism incident or other actual or potential public health emergency; (ii) it is necessary to permit the provision of needed drugs or devices; and (iii) such persons have received the training necessary to safely administer or dispense the needed drugs or devices. Such persons shall administer or dispense all drugs or devices under the direction, control and supervision of the State Health Commissioner.

M. Nothing in this title shall prohibit the administration of normally self-administered oral or topical drugs by unlicensed individuals to a person in his private residence.

N. This section shall not interfere with any prescriber issuing prescriptions in compliance with his authority and scope of practice and the provisions of this section to a Board agent for use pursuant to subsection G of § 18.2-258.1. Such prescriptions issued by such prescriber shall be deemed to be valid prescriptions.

O. Nothing in this title shall prevent or interfere with dialysis care technicians or dialysis patient care technicians who are certified by an organization approved by the Board of Health Professions pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.) of this title, in the ordinary course of their duties in a Medicare-certified renal dialysis facility, from administering heparin, topical needle site anesthetics, dialysis solutions, sterile normal saline solution, and blood volumizers, for the purpose of facilitating renal dialysis treatment, when such administration of medications occurs under the orders of a licensed physician, nurse practitioner or physician assistant and under the immediate and direct supervision of a licensed registered nurse.

The dialysis care technician or dialysis patient care technician administering the medications shall have demonstrated competency as evidenced by holding current valid certification from an organization approved by the Board of Health Professions pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.) of this title.

(Code 1950, § 54-497; 1956, c. 225; 1970, c. 650, § 54-524.65; 1973, c. 468; 1976, cc. 358, 614; 1977, c. 302; 1978, c. 224; 1980, cc. 270, 287; 1983, cc. 456, 528; 1984, cc. 141, 555; 1986, c. 81; 1987, c. 226; 1988, c. 765; 1990, c. 309; 1991, cc. 141, 519, 524, 532; 1992, cc. 610, 760, 793; 1993, cc. 15, 810, 957, 993; 1994, c. 53; 1995, cc. 88, 529; 1996, cc. 152, 158, 183, 406, 408, 490; 1997, cc. 272, 566, 806, 906; 1998, c. 112; 1999, c. 570; 2000, cc. 135, 498, 861, 881, 935; 2003, cc. 465, 497, 515, 794, 995, 1020.)

§ 22.1-275. Protective eye devices.

Every student and teacher in any school, college, or university shall be required to

wear industrial quality eye protective devices while participating in any of the following courses or laboratories:

1. Career and technical education shops or laboratories involving experience with:

a. Hot molten metals,

b. Milling, sawing, turning, shaping, cutting, grinding, or stamping of any solid materials,

c. Heat treatment, tempering, or kiln firing of any metal or other materials,

d. Gas or electric arc welding,

e. Repair of any vehicle, or

f. Caustic or explosive materials;

2. Chemical or combined chemical-physical laboratories involving caustic or explosive chemicals or hot liquids or solids.

The governing board or authority of any public or private school or the governing body of each institution of higher learning shall furnish the eye protective devices prescribed in this section free of charge or at cost to the students and teachers of the school participating in such courses or laboratories; however, such devices may be furnished by parents or guardians of such students. Eye protective devices shall be furnished to all visitors to such courses. "Industrial quality eye protective devices," as used in this section, means devices providing side protection and meeting the standards of the American Standards Association Safety Code for Head, Eye, and Respiratory Protection, Z2.1-1959, promulgated by the American Standards Association, Inc.

(Code 1950, § 22-10.2; 1966, c. 69; 1980, c. 559; 2001, c. 483.)

§ 22.1-275.1. School health advisory board.

Each school board shall establish a school health advisory board of no more than twenty members which shall consist of broad-based community representation including, but not limited to, parents, students, health professionals, educators, and others. The school health advisory board shall assist with the development of health policy in the school division and the evaluation of the status of school health, health education, the school environment, and health services.

The school health advisory board shall hold meetings at least semi-annually and shall annually report on the status and needs of student health in the school division to any relevant school, the school board, the Virginia Department of Health, and the Virginia Department of Education.

The local school board may request that the school health advisory board recommend to the local school board procedures relating to children with acute or chronic illnesses or conditions, including, but not limited to, appropriate emergency procedures for any life-threatening conditions and designation of school personnel to implement the appropriate emergency procedures. The procedures relating to children with acute or chronic illnesses or conditions shall be developed with due consideration of the size and staffing of the schools within the jurisdiction.

(1990, c. 315; 1992, c. 174; 1999, c. 570.)

§ 22.1-279.8. School safety audits and school crisis and emergency management plans required.

A. For the purposes of this section, unless the context requires otherwise:

"School crisis and emergency management plan" means the essential procedures, operations, and assignments required to prevent, manage, and respond to a critical event or emergency, including natural disasters involving fire, flood, tornadoes, or other severe weather; loss or

disruption of power, water, communications or shelter; bus or other accidents; medical emergencies; student or staff member deaths; explosions; bomb threats; gun, knife or other weapons threats; spills or exposures to hazardous substances; the presence of unauthorized persons or trespassers; the loss, disappearance or kidnapping of a student; hostage situations; violence on school property or at school activities; incidents involving acts of terrorism; and other incidents posing a serious threat of harm to students, personnel, or facilities.

"School safety audit" means a written assessment of the safety conditions in each public school to (i) identify and, if necessary, develop solutions for physical safety concerns, including building security issues and (ii) identify and evaluate any patterns of student safety concerns occurring on school property or at school-sponsored events. Solutions and responses shall include recommendations for structural adjustments, changes in school safety procedures, and revisions to the school board's standards for student conduct.

B. The Superintendent of Public Instruction shall develop a list of items to be reviewed and evaluated in the school safety audits required by this section. Each local school board shall require all schools under its supervisory control to annually conduct school safety audits as defined in this section and consistent with such list.

The results of such school safety audits shall be made public within 90 days of completion. The local school board shall retain authority to withhold or limit the release of any security plans and specific vulnerability assessment components as provided in § 2.2-3705. Each school shall maintain a copy of the school safety audit, which may exclude such security plans and vulnerability assessment components, within the office of the school principal and shall make a copy of such report available for review upon written request. Each school shall submit a copy of its school safety audit to the relevant school division superintendent. The division superintendent shall collate and submit all such school safety audits to the Virginia Center for School Safety.

C. The school board may establish a school safety audit committee to consist of representatives of parents, teachers, local law-enforcement agencies, judicial and public safety personnel, and the community at large. The school safety audit committee shall evaluate, in accordance with the directions of the local school board, the safety of each school and submit a plan for improving school safety at a public meeting of the local school board.

D. Each school board shall ensure that every school that it supervises shall develop a written school crisis and emergency management plan, consistent with the definition provided in this section. The Department of Education and the Virginia Center for School Safety shall provide technical assistance to the school divisions of the Commonwealth in the development of the school crisis and emergency management plans.

Upon consultation with local school boards, division superintendents, the Virginia Center for School Safety, and the Coordinator of Emergency Management, the Board of Education shall develop, and may revise as it deems necessary, a model school crisis and emergency management plan for the purpose of assisting the public schools in Virginia in developing viable, effective crisis and emergency management plans. Such model shall set forth recommended effective procedures and means by which parents can contact

the relevant school or school division regarding the location and safety of their school children and by which school officials may contact parents, with parental approval, during a critical event or emergency.
(1997, c. 593; 1999, cc. 475, 516, § 22.1-278.1; 2001, cc. 436, 440, 688, 820, 841; 2002, cc. 166, 221, 229, 235; 2003, c. 801.)

APPENDIX C

SCHOOL HEALTH ADVISORY BOARD (SHAB) ANNUAL REPORT FORM 2003-04 SCHOOL YEAR

IDENTIFYING INFORMATION

School Division:
SHAB Chairperson:
Address:

Telephone: ( ) Fax: ( )

Person Completing this Report: Date:
Telephone: ( ) Fax: ( )

E-Mail Address:

STRUCTURE AND OPERATION OF YOUR SHAB

A. Membership

Please identify the composition of your SHAB by marking the appropriate boxes with the number of SHAB members in each category. Count members in all appropriate categories; e.g., a member may be a "PTA representative" and a "Medical professional."

Parent
_____ Parent of a school aged child
_____ Parent of a medically fragile child
_____ PTA representative
_____ Resource center representative

Community Representative
_____ Civic group
_____ Religious group
_____ Human services
_____ Youth services

Health Professional
_____ Medical
_____ Dentistry
_____ Mental Health
_____ Public Health
_____ Other (specify) _____

Educator
_____ School nurse
_____ Health Teacher
_____ Physical Education Teacher
_____ Other Teacher
_____ Administrator
_____ Program supervisor
_____ Counselor
_____ Food Services
_____ Other (specify) _____

_____ **Student**

Miscellaneous
_____ Business
_____ Government Official
_____ Law Enforcement
_____ Other (specify) _____

Total number of members (unduplicated count)**:** _____

Does your School Health Advisory Board serve as the forum for leadership for multiple committees (e.g., part of PTA, Safe and Drug Free School Committee, etc.)? YES ☐ NO ☐
If yes, explain:

Are there other boards in your school division that work on issues that might be relevant to your SHAB?
YES ☐ NO ☐

If yes, list:

B. Meetings

How many general meetings did your SHAB hold this school year (excluding subcommittee meetings)?
_____ meetings

How many subcommittee meetings did your SHAB hold this school year? _____ meetings
List subcommittees: _____

C. Reports

How many reports did your SHAB make during this school year to:

(1) Your local school board? _____ Written reports _____ Oral reports

(2) Central office personnel? _____ Written reports _____ Oral reports

(3) Other groups?

(name) _____ Written reports _____ Oral reports

(name) _____ Written reports _____ Oral reports

D. Operating Procedures

Does your SHAB have operating procedures/bylaws?
YES ☐ NO ☐

Have you made any changes to your operating procedures/bylaws for your SHAB in the past year?

YES ☐ (please attach a copy if revised in the past year)

NO ☐

GOALS AND ACCOMPLISHMENTS

A. Goals

In the first column, check the goals that were identified by your SHAB for this school year. In the second column, check the goals that were accomplished.

	Identified Goals	**Accomplished Goals**
Health Services		
Increase school nursing staff	☐	☐
Develop/improve school health services	☐	☐
Develop/improve student wellness	☐	☐
Review procedures for student health screening, record keeping, and referrals	☐	☐
Health Education/Instruction		
Review health education curriculum	☐	☐
Review health education assessment	☐	☐
Reduce teen pregnancy	☐	☐
Develop/revise Family Life Education Curriculum	☐	☐
Revise HIV Policy for School Attendance	☐	☐
Reduce drug, alcohol, and/or tobacco use	☐	☐
Healthy Environment		
Review emergency/crisis medical situations	☐	☐
Review school health policies	☐	☐
Review school safety procedures	☐	☐
Physical Education		
Review physical education curriculum	☐	☐
Review physical education assessment	☐	☐
Review availability of instructional resources	☐	☐
Increase student's physical activity	☐	☐
Nutrition Services		
Review school nutrition program procedures and offerings	☐	☐
Counseling		
Review psychological and social services for diagnosing special needs for students	☐	☐
Review counseling services for helping students set education and social goals	☐	☐

	Identified Goals	Accomplished Goals
Staff Wellness		
Review staff wellness initiatives	☐	☐
Parent/Community Involvement		
Improve parent communication/education	☐	☐
Develop/maintain community partnerships	☐	☐
Other		
Conduct a needs assessment/data collection	☐	☐
Please list topic(s): _____		
Improve operations of SHAB	☐	☐
Other (specify) _____	☐	☐

B. Successes

Please describe your SHAB's two greatest accomplishments this school year. What were your goals and what projects/activities were used to meet the identified goals? How many students did it impact? Who were your community partners? Add an additional sheet, if necessary.

Will you allow the Virginia Department of Education to post/share information about your successes on its Web site? YES ☐ NO ☐

ADDITIONAL INFORMATION

Use this space to provide additional information about your SHAB that you feel is important to share.

Use this space to indicate whether you would like some assistance from the VDH or DOE and the nature of the assistance needed.

SCHOOL HEALTH ADVISORY BOARD

2004-2005 Point of Contact

Below, please provide the name of the individual you wish to serve as the point of contact for your local School Health Advisory Board (SHAB) during the 2004-05 school year. (In many localities, the SHAB chair or a school contact person serves this role.) Any resources or information relevant to SHABs will be distributed to this person.

Date Submitted:

School Division:

Name of "Point of Contact":

Position or Role on the SHAB:

Mailing
Address:

Telephone ( ) Fax: ( )

E-Mail:

Please return this form by July 1, 2004 (via fax, email or regular mail) to:

Muriel Azria-Evans, PhD, CFLE
Comprehensive School Health Specialist
Virginia Department of Education
P.O. Box 2120
Richmond, VA 23218
Phone: 804-225-4543
Fax: 804-371-8796
Email: mazria-e@mail.vak12ed.edu

Questions may be addressed to Muriel Azria-Evans at the phone number or e-mail address above.

Thank you for your participation!

APPENDIX D
Self-Evaluation of the School Health Advisory Board

Self-evaluation is ongoing, whether by individual members or more formally. One means of assessing the effectiveness of a school health advisory board is to conduct a survey of board members using a checklist such as the following:

	Yes	**No**
Is there a statement of purpose and goals for your group?	( )	( )
Are the school health advisory board activities benefiting the school health program?	( )	( )
Have school health advisory board activities developed community understanding of the school health program?	( )	( )
Do school health advisory board members understand their roles and what is expected of them?	( )	( )
Are school health advisory board members aware of the status of school health programs in most schools in the school division?	( )	( )
Are members provided information on state and national developments in school health?	( )	( )
Have members received sufficient orientation to the schools and to the school health program?	( )	( )
Is the school health advisory board given sufficient information and time to study and discuss issues before making recommendations?	( )	( )
Does the school health advisory board membership reflect varying and opposing viewpoints?	( )	( )
Are meetings conducted in an impartial manner allowing all members to express opinions?	( )	( )
Is the importance of members' time recognized through keeping meetings on schedule and directed to agenda?	( )	( )
Are school health advisory board activities or projects selected with care and limited to a reasonable number?	( )	( )

	Yes	No
Are school health advisory board members presented the facts and consulted when changes are made in the school health program?	( )	( )
Do members receive adequate advance notice of meetings? and prompt reports of minutes?	( )	( )
Are members involved in assignments based upon their expertise?	( )	( )
Does the chairperson or a few members dominate meetings?	( )	( )
Are membership rosters current and updated?	( )	( )
Are members asked for recommendations on improving the effectiveness of meetings?	( )	( )
Does the school health advisory board encourage school administrators to meet with the council or individual members on selected issues?	( )	( )
Are members invited to school functions such as graduation, open houses, exhibits, athletic events, plays, etc.?	( )	( )
Are members encouraged to visit health classes?	( )	( )
Does the school health advisory board hold a "thank you event" or dinner for all members?	( )	( )
Does the membership have adequate representation of ethnic and economic groups in community?	( )	( )
Are members given recognition for contributions in school publications, news releases, or other methods?	( )	( )
Is there a reflection of positive support from school personnel for the school health advisory board members' services?	( )	( )

Adapted from Fraser, Katherine. *Someone at School has AIDS: A Guide to Developing Policies for Students and School Staff Members Who Are Infected with HIV*. National Association of State Boards of Education, 1989.

APPENDIX E

Action Planning Worksheet

_____ (School Health Advisory Board Name)

Vision Statement					
Mission Statement					
Goal or Priority					
Relationship of Goal to Vision/Mission Statement(s)					
What is the Critical Indicator(s) of success of Goal/Priority					
Action Steps or Activities to meet goal	**Start Date**	**Completion Date**	**Resources Needed to ensure success**	**Person(s) Responsible**	**How is success measured?**

APPENDIX F
References

Allen, J. P., Philliber, S., Herrling, S., & Kupermine, G. P. (1997). Preventing teen pregnancy and academic failure: Experimental evaluation of a developmentally based approach. *Child Development, 64* (4), 729-742.

Allensworth, D., & Kolbe, L. (1987). The comprehensive school health program: Exploring and expanded concept. *Journal of School Health, 57,* 409.

American Cancer Society. (2003). *Promoting healthy youth, schools, and communities: A guide to community-school health councils*. Atlanta, GA, American Cancer Society.

American Cancer Society. (1994). *Values and opinions of comprehensive school health education in U.S. public schools: Adolescents, parents, and school district*. Atlanta, GA, American Cancer Society.

Berner, M. (1993). Building conditions, parental involvement, and student achievement in the District of Columbia public school system. *Urban Education, 28* (1), 6-29.

Cain, D. (1997). *The board team planning manual: A complete guide to long-range planning for the board team*, Hawarden, IA: The Cain Consulting Group.

Calfas, K. & Taylor, W. (1994). Effects of physical activity on psychological variables in adolescents. *Pediatric Exercise Science, 6,* 406-423.

Drolet, J. C., & Fretto, J. V. (1993). State conferences for school worksite wellness: Personal health practices of conference participants. *Journal of Health Education, 24,* 174-183.

Dwyer, T., Blizzard, L., & Dean, K. (1996). Physical activity and performance in children. *Nutrition Reviews, 54* (4), S27-S31.

Education Commission of the States (1996). *Youth violence: A policymaker's guide.* Denver, CO.

Eggert, L., Thompson, E., Herting, J., Nicholas, L., & Dicker, B. (1994). Preventing adolescent drug abuse and high school dropout through an intensive school-based social network development program. *American Journal of Health Promotion, 8* (3), 202-215.

Elias, M., Gara, M., Schuyler, T., Branden-Muller, L., & Sayette, M. (1991). The promotion of social competence: Longitudinal study of a preventive school-based program. *American Journal of Orthopsychiatry, 61* (3), 409-417.

Errecart, M. T., Walberg, H. J., Ross, J. G., Gold, R. S., Fiedler, J. L., & Kolbe, L. J. (1991). Effectiveness of teenage health teaching models. *Journal of School Health, 61(special insert)*(1), 26-30.

Fries, J. F., Harrington, H. Edwards, R., Kent, L. A., & Richardson, N. (1994). Randomized controlled trial of cost reductions from a health education program: The California Public Employees Retirement System (PERS) study. *American Journal of Health Promotion, 8,* 216-223.

Hanson, T. L., & Austin, G. A. (2002). *Health risks, resilience, and the Academic Performance Index.* (California Healthy Kids survey Factsheet 1). Los Alamitos, CA: WestEd.

Hawkins, J., Catalano, R., Kosterman, R., Abbott, R., & Hill, K. (1999). Preventing adolescent health-risk behaviors by strengthening protection during childhood. *Archives of Pediatric Adolescent Medicine, 153,* 226-234.

Henderson, A. (1987). *The evidence continues to grow: Parent involvement improves student achievement*. Columbia, MD: National Committee for Citizens in Education.

Institute of Medicine (1997). *Schools and health: Our nation's investment.* D. Allensworth, E. Lawson, L. Nicholson, & J. Wyche (Eds.). Washington, DC: National Academic Press.

Knitzer, J., Steinberger, A., & Fleisch, B. (1990). *At the schoolhouse door: An examination of programs and policies for children with behavioral and emotional problems.* New York: Bank Street College of Education.

Marx, E., Wooley, S. F., & Northrup, D. (Eds.) (1998). *Health is Academic: A Guide to Coordinated School Health Programs*. Washington, D.C.: Education Development Center, Inc.

McCord, M., Klein, J., Foy, J., & Fothergill, K. (1993). School-based clinic use and school performance. *Journal of Adolescent Health, 14*(2), 91-98.

Meyers, A., Sampson, A., Weitzman, M., Rogers, B., & Kayne, H. (1989). School breakfast program and school performance. *American Journal of Diseases of Children, 143*, 1234-1239.

Murphy, J., Pagano, M., Nachmani, J., Sperling, P., Kane, S., & Kleinman, R. (1998). The relationship of school breakfast to psychosocial and academic functioning. *Archives of Pediatric Adolescent Medicine, 152,* 899-907.

Nettles, S. (1991). Community involvement and disadvantaged students: A review. *Review of Educational Research 61*(3), 379-406.

North Carolina Department of Public Instruction. (1991). *Establishing and Maintaining School Health Advisory Councils: A How-To Manual for Local Education Agencies*. Raleigh, NC: Division of Curriculum and Instruction.

Pruitt, R. H., Bernheim, C. & Tomlinson, J. P. (1991). Stress management in a military health promotion program: Effectiveness and cost efficiency. *Military Medicine, 156,* 51-53.

Reynolds, A., Temple, J., Robertson, D., & Mann, E. (2001). Long-term effects of an early childhood intervention on educational achievement and juvenile arrest: A 15-year follow-up of low-income children in public schools. *Journal of the American Medical Association, 285*(18), 2339-2346.

Schoener, J., Guerrero, F., & Whitney, B. (1988). *The effects of the Growing Healthy program upon children's academic performance and attendance in New York City*. Report from the Office of Research, Evaluation and Assessment to the New York City Board of Education.

Sallis, J., McKenzie, T., Kolody, B., Lewis, M., Marshall, S., & Rosengard, P. (1999). Effects of health-related physical education on academic achievement: Project SPARK. *Research Quarterly for Exercise and Sport, 70*(2), 127-134.

Shirer, K. (2003). *Promoting healthy youth, schools and communities: A guide to community-school health councils.* American Cancer Society.

Simons-Morton, B., Crump, A., Haynie, D., & Saylor, K. (1999). Student-school bonding and adolescent problem behavior. *Health Education Research, 14*(1), 99-107.

Symons, C.W., Cummings, C.D., & Olds, R.S. (1994). Health People 2000: An agenda for schoolsite health promotion programming. In D.D. Allenworth, C.W. Symons, & R.S. Olds (Eds.), *Healthy Students 2000: An agenda for continuous improvement in America's schools* (pp. 137-144). Kent, OH: American School Health Association.

U.S. Department of Health and Human Services. (2003). *Stories from the field: lessons learned about building coordinated school health programs*. Atlanta, GA: Division of Adolescent and School Health, Centers for Disease Control and Prevention.

Walters, G. (1996). *A comparison of absentee/attendance rates in high schools with and without school based health clinics*. Thesis submitted to Michigan State University.

APPENDIX G
Sample Resources from National Organizations

Advocates for Youth

1025 Vermont Ave., N.W.

Suite 200
Washington, DC 20005
(202) 347-5700
Fax: (202) 347-2263
Kayla Jackson, Director, HIV/STD Prevention Programs
www.advocatesforyouth.org

- Youth Development: Strengthening Prevention Strategies
- Adolescents, HIV/AIDS, and Other STDs
- Adolescent Pregnancy and Childbearing
- Abstinence Until Marriage Education
- Youth Involvement in Prevention Programming

American Association for Health Education (AAHE/AAHPERD)

1900 Aviation Drive
Reston, VA 20191-1599
(703) 476-3437
Fax: (703) 476-6638
Becky Smith, Executive Director, Health Education and Aging Project
Jackie Lance, Administrative Assistant
www.aahperd.org/aahe

- National Health Education Standards – stock number 301-10035
- Ready for Teaching Health: Preparing the Student Teacher for School Health – stock number 301-10054
- Service Learning in Health Education – stock number 301-10064
- Health is Academic
- STDs and HIV: A Guide for Today's Young Adults – stock number A534-0 – Instructor's Manual; A533-2 – Student Guide
- What Every Health Educator Should Know About HIV/AIDS Education – stock number 301-20046
- HIV Prevention Education for Teachers of Elementary and Middle Schools (how to assess students' personal feelings about HIV and how to respond to questions) – stock number 301-10022

American School Health Association (ASHA)

7263 State Route 43
P.O. Box 708
Kent, OH 44240
(330) 678-1601
Fax: (330) 678-4526
Susan Wooley, Executive Director
www.ashaweb.org

- Health is Academic
- School Health: Findings from Evaluated Programs, 2nd Edition
- National Health Education Standards: Achieving Health Literacy

- Guidelines for Protecting Confidential Student Health Information
- Building Effective Coalitions to Prevent the Spread of HIV: Planning Considerations
- Tell Me About AIDS (includes teacher, student, and parent materials for K-6)
- Sexuality Education with Comprehensive School Health Education
- A Comprehensive Approach to Reduce Pregnancy and the Spread of HIV: An Advocacy Kit

Association of State and Territorial Health Officials (ASTHO)

1275 K Street, N.W.
Suite 800
Washington, DC 20005
(202) 371-9090
Fax: (202) 371-9797
Amy Green, Director of Adolescent and School Health Policy
www.astho.org

- Coordinated School Health Starter Kit
- Issue Brief on Adolescent Decision Making
- Mental Health Tool Kit
- Teen Pregnancy Tool Kit
- Adolescent and School Health Newsletters
- Public Substance Abuse Agency Initiatives in HIV Prevention for Adolescents, American Public Welfare Association, April, 1998
- ASTHO-NACCHO Policy Statement on Tobacco Use Prevention and Control Tobacco Free Press, 2 most recent issues, see ”Projects - Tobacco

Comprehensive Health Education Foundation (C.H.E.F.)

22419 Pacific Highway South
Seattle, WA 98198
(206) 824-2907
Fax: (206) 824-3072
Gail Tanaka, Project Director
www.chef.org

- Middle Level Health Promoting Schools Project

Council of Chief State School Officers (CCSSO)

One Massachusetts Ave., N.W.
Suite 700
Washington, DC 20001-1431
(202) 408-5505
Fax: (202) 408-8072
Nora Howley, Project Director, Resource Center on Educational Equity
www.ccsso.org

- The School Health Starter Kit
- Publication on state education agencies
- Publication on teen pregnancy prevention
- Document on incorporating health indicators into state accountability systems.
- Early Warning, Timely Response: A Guide to Safe Schools (www.ed.gov/offices/OSERS/OSEP/earlywrn.html)

- Announcement: The Expert Panel on Safe, Disciplined, and Drug Free Schools Searching for Best Programs: Expert Panel Identifies Nine Exemplary and Thirty-three Promising Programs (www.ed.gov/offices/OSERS/OSEP/earlywrn.html)
- Guidelines for School Health Programs to Prevent Tobacco Use and Addiction (www.cdc.gov/nccdphp.dash/nutptua.htm)
- CDC Programs That Work to Reduce Tobacco Use (www.cdc.gov.nccdphp/dash/rtc/tob-curric.htm)
- Learning First Alliance – Every Child Learning: Safe and Supportive Schools (www.learningfirst.org)

Educational Development Center (EDC)

55 Chapel Street
Newton, MA 02158-1060
(617) 969-7100
Fax: (617) 244-3436
Evelyn Frankford, Project Director, Making Health Academic
Yvette Lamb, Project Director, National Training Center for Middle School Drug Abuse Prevention and School Safety
www2.edc.org/MakingHealthAcademic/
www.edc.org/MSC

- See the Web site as a resource
- Vast resources for the needs of middle school coordinators in the US Department of Education's Safe and Drug Free Schools program. These resources are also appropriate for school and community personnel in this same area.
- Any resources or information on the Web site, http://www2.edc.org/MakingHealthAcademic/

Education, Training, and Research Associates (ETR)

Education, Training, and Research Associates
4 Carbonero Way
Scotts Valley, VA CA 95066-4200
Phone: 800-325-3048
Fax: 831-438-4284
Email: jhl@etr.org
John Henry Ledwith, Publishing
www.pub.etr.org

Girls Incorporated (Girls, Inc.)

National Resource Center
441 W. Michigan Street
Indianapolis, IN 46202-3287
(317) 634-7546
Fax: (317) 634-3024
Sara Riester, Program Associate to Bernice Humphrey, Director
www.girlsinc.org

- Publications list is on their Web site, but in addition, also recommended are "FACT Sheets": 'Girls and HIV, AIDS, and STDs'; 'Girls and Tobacco Use'; 'Girls and Drug Use'; 'Girls and Sexual Health'; and 'Girls and Sexual Activity'.

Institute for Youth Development (IYD)

P.O. Box 16560
Washington, DC 20041
(703) 471-8750
Fax: (703) 471-
www.youthdevelopment.org

National Alliance of State and Territorial AIDS Directors (NASTAD)

444 N. Capital Street, N.W.
Washington, DC 20001-1521
(202) 434-8090
Fax: (202) 434-8092
Rebecca Wong, HIV/STD Prevention Youth Specialist
www.nastad.org

- Youth Involvement in the Community Planning Process: A Special Focus on Youth of Color, A NASTAD Report (www.nastad.org/documents/public/PUB_PREVENTION/2001720YouthofColotTAReport.pdf)
- November 2000 Bulletin on School and Health Agency Collaboration (www.nastad.org/DOCUMENTS/PUBLIC/PUB_PREVENTION/200126NOVEMBER2000.pdf)
- Youth Resolution (www.nastad.org/news.asp?article_id=87

National Association of Community Health Centers (NACHC)

1330 New Hampshire Avenue, N.W.
Suite 122
Washington, DC 20036
(202) 659-8008
Fax: (202) 659-8519
Leslie Morris, Project Manager, Adolescent and School Health Initiative
www.nachc.com

National Association of School Nurses (NASN)

P.O. Box 1300
Scarborough, ME 04070-1300
1-877-627-6476
(207) 883-2117
(207) 883-2683
nasn@nasn.org

National Association of State Boards of Education (NASBE)

277 S. Washington Street
Suite 100
Alexandria, VA 22314
(703) 684-4000
Fax: (703) 836-2313
Jim Bogden, Project Director, HIV Prevention/Healthy Schools Project
www.nasbe.org

- Fit, Healthy and Ready to Learn
- Someone at School Has AIDS
- Schools Without Fear

- Building Business Support for School Health Programs
- The Impact of Adolescent Pregnancy and Parenthood on Educational Achievement
- The "links page" on the Healthy Schools Web site (www.nasbe.org/healthyschools/index.mgi)

National Association of Student Personnel Administrators (NASPA)

1875 Connecticut Avenue, N.W.
Suite 418
Washington, DC 20009-5728
(202) 265-7500
Fax: (202) 797-1157
William O'Connell, Jr., Director, Health Education and Leadership Program
www.naspa.org

National Center for Health Education (NCHE)

72 Spring Street
Suite 208
New York, NY 10012
(212) 334-9470
Fax: (212) 334-9845
Lynne Whitt, Executive Vice President
www.nche.org

- Growing Healthy®: K-6 Comprehensive School Health Education Curriculum
- Growing Healthy®: Online Training (Professional Preparation for Teachers of Growing Healthy®
- Tobacco Free: It's Elementary

National Commission on Correctional Health Care (NCCHC)

1300 W. Belmont Avenue
Chicago, IL 60657
(773) 880-1460
Fax: (773) 880-2424
Mindy Ferguson, Juvenile Health Program Director, Comprehensive HIV Education and Prevention for Incarcerated Youth
www.ncchc.org

- HIV Prevention Training Program for Incarcerated Youth
- Standards for Health Care Delivery in Juvenile Facilities

National Conference of State Legislatures (NCSL)

1560 Broadway
Suite 700
Denver, CO 80202-5140
(303) 863-2200
Fax: (303) 863-8003
Louise Bauer, Program Manager, Adolescent and School Health Project
www.ncsl.org

National Council of LaRaza (NCLR)

1111 19th Street, N.W.
Suite 1000
Washington, DC 20036
(202) 785-1670
Fax: (202) 776-1792
Raul Yzaguirre, President
www.nclr.org

- HIV is an STD: A Guide for Integrating HIV/STD Prevention Education
- Reducing Hispanic Teenage Pregnancy and Family Poverty: A Replication Guide
- Latino Health Beliefs: A Guide for Health Care Professionals
- HIV/STD Program Evaluation: Understanding Evaluation Techniques: The Building Blocks of Evaluation
- Breast and Cervical Cancer Among Latino Women (A booklet with general information and fact sheets)
- Childhood Immunization in the Hispanic Community, 1997
- Needle Exchange Programs for the Prevention of HIV: Their Impact on the Latino Community
- Do's and Don'ts for an Inclusive HIV Prevention Community Planning Process: A Self-Help Guide

National Education Association (NEA)

Health Information Network
1201 16th Street, N.W.
Washington, DC 20036
(202) 822-7570
Fax: (202) 822-7775
Jerald Newberry, Executive Director
Vicki Harrison, Project Coordinator, Teen Pregnancy Project
www.neahin.org and www.canwetalk.org

- "Can We Talk": parent education training modules for parents.

National Governors' Association (NGA)

444 N. Capital Street
Suite 267
Washington, DC 20001
(202) 624-5300
Fax: (202) 624-5313
Liam Goldrick, Policy Analyst, Education Policy Studies Division

- Issue Brief: Improving Academic Performance by Meeting Student Health Needs (http://www.nga.org/cda/files/001013PERFORMANCE.PDF)
- Issue Brief: Extra Learning Opportunities that Encourage Healthy Lifestyles (http://www.nga.org/cda/files/000125ELO.pdf)
- Issue Brief: States' Role in Preventing Teenage Pregnancy (http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_605,00.html)
- Coordinated School Health Web site: http://www.nga.org/CBP/Activities/SchoolHealth.asp
- Issue Brief: Making Schools Safe (http://www.nga.org/cda/files/19990823SAFESCHOOLS.pdf
- Issue Brief: Building Bridges Across Systems (http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_314,00.html)
- Dealing with Violent Juvenile Offenders (http://www.nga.org/cda/files/000214JUVCRIME.pdf)
- Issue Brief: Preventing Maternal Smoking (http://www.nga.org/cda/files/071101SMOKING.pdf)

National Middle School Association (NMSA)

4151 Executive Parkway
Suite 300
Westerville, OH 43081
(800) 528-6672
Fax: (614) 895-4750
Jean Schultz, Project Director
www.nmsa.org

- This We Believe…and Now We Must Act

National Network for Youth (NNY)

1319 F Street, N.W.

Suite 401
Washington, DC 20004
(202) 783-7949
Fax: (202) 783-7955
Gretchen Noll, Project Director, Healthy Youth Futures Project
www.nn4youth.org

- Issue Brief 1: Community Planning for HIV Prevention & Services: What's in it for You?
- Issue Brief 2: Sexual Abuse, Non-consensual Sex and HIV Prevention for Youth
- Issue Brief 3: Adolescents and Health Behavior Theory
- Issue Brief 4: Understanding Public Health Research: A Primer for Youth Workers
- Issue Brief 5: HIV Prevention for Two Populations of Youth in High-Risk Situations – Homeless Youth and Sexual Minority Youth
- Tool Kit for Youth Workers: Fact Sheet – September 1998; Runaway and Homeless Youth
- Took Kit for Youth Workers: Bibliography – January 1999; HIV and Homeless/Street Youth
- Tool Kit for Youth Workers: Fact Sheet – September 1998; HIV Infection in Sexual Minority Youth
- Tool Kit for Youth Workers: Bibliography – January 1999; HIV and Sexual Minority Youth

National School Boards Association (NSBA)

1680 Duke Street
Alexandria, VA 22314
(703) 838-6722
Fax: (703) 683-7590
Brenda Greene, Director, School Health Programs
www.nsba.org

- A Call to Action: What Schools Can Do to Prevent Teen Pregnancy and Promote Student Achievement—a joint project with the National Association of State Boards of Education)
- Reducing the Risk: A School Leader's Guide to AIDS Education
- Why Vouchers Won't Work: A Tool Kit for School Board Members
- Tobacco Prevention 101 Packet
- Keep Schools Safe, www.keepschoolssafe.org a Web site of "collected resources to help make schools safer" (a joint project with the National Association of Attorneys General)

Public Education Network (PEN)

601 13th Street, N.W.
Washington, DC 20005-3808
(202) 628-7460
Fax: (202) 628-1893

Richard Tagle, Senior Associate, Comprehensive School Health Initiative
Karima Morris, Program Coordinator, Comprehensive School Health Initiative
www.publiceducation.org

- Lessons from the Field: Increasing Safety in America's Public Schools
- Violence Touches the Lives of too Many Children. Help Stop the Violence (from the Children's Defense Fund) – a booklet
- Safe Schools and Safe Students: A Guide to Violence Prevention Strategies
- Violent Kids: Can We Change Trends?
- Quality Now! Results of National Conversations on Education and Race
- Lessons from the Field: Part Three: Creating and Managing Change Through Comprehensive School Health Programs **and** Part Four: Creating Lasting Comprehensive School Health Programs
- Community Counts: How Youth Organizations Matter for Youth Development
- School Finance Toolkit: How to Understand Your School Budget
- Lessons from the Field: Do Public Schools Fail Girls?

Rocky Mountain Center for Health Promotion and Education (RMC)

7525 W. 10th Ave.
Lakewood, CO 80215
(303) 239-6796
Mary A. Doyan, Executive Director
Debra Sandau-Christopher, Professional Development Partnership
www.rmc.org

Sexuality Information and Education Council of the U.S. (SIECUS)

130 W. 42nd Street
Suite 350
New York, NY 10036
(212) 819-9770
Fax: (212) 819-9776
Monica Rodriguez, Director of Information and Education

APPENDIX H

Tools for Schools to Prevent Chronic Diseases

From: Division of Adolescent and School Health,
National Center for Chronic Disease Prevention and Health Promotion

Guidelines and Strategies:

- Guidelines for School Health Programs to:
  - Promote Lifelong Physical Activity Among Young People
  - Promote Lifelong Healthy Eating
  - Prevent Tobacco Use and Addiction

  Centers for Disease Control and Prevention
  www.cdc.gov/nccdphp/dash/publications/schoolguidelines.htm
- Ten Strategies for Physical Activity, Healthy Eating, and a Tobacco-Free Lifestyle Through School Health Programs
  Centers for Disease Control and Prevention
  http://www.cdc.gov/nccdphp/dash/publications/pdf/ten_strategies.pdf
- Strategies for Addressing Asthma in a Coordinated School Health Program
  Centers for Disease Control and Prevention
  http://www.cdc.gov/nccdphp/dash/asthma/index.htm#strategies
- Building a Healthier Future Through School Health Programs
  Centers for Disease Control and Prevention
  http://www.cdc.gov/nccdphp/promising_practices/pdfs/SchoolHealth.pdf
- The Role of Michigan Schools in Promoting Healthy Weight
  Michigan Department of Education
  http://www.michigan.gov/documents/healthyweight_13649_7.pdf

Coordinated School Health Program

- Health is Academic: A Guide to Coordinated School Health Programs
  Teachers College Press
  www.teacherscollegepress.com
- Improving School Health: A Guide to School Health Councils
  American Cancer Society
  www.schoolhealth.info (Click on "Advisory Councils")
- Making Health Academic (web site)
  Education Development Center, Inc.
  http://www2.edc.org/MakingHealthAcademic/about.asp
- Making the Connection: Health and Student Achievement (slide show)
  Society of State Directors of Health, Physical Education and Recreation
  www.thesociety.org/
- Stories from the Field: Lessons Learned About Building Coordinated School Health Programs
  Centers for Disease Control and Prevention
  http://www.cdc.gov/nccdphp/dash/publications/stories.htm
- School Health Starter Kit
  Council of Chief State School Officers
  www.ccsso.org/publications/details.cfm?PublicationID=59

Self-Assessment and Planning

- School Health Index for Physical Activity, Healthy Eating, and a Tobacco-Free Lifestyle: A Self-Assessment and Planning Guide
  Centers for Disease Control and Prevention
  http://www.cdc.gov/nccdphp/dash/SHI/index.htm

Policy Review

- Fit, Healthy, and Ready to Learn: A School Health Policy Guide
  National Association of State Boards of Education
  www.nasbe.org/healthyschools/fithealthy.mgi
- Generation Fit Action Packet
  American Cancer Society
  www.cancer.org/docroot/PED/content/PED_1_5X_Generation_Fit.asp
- Healthy Schools – State Level School Health Policies (database)
  National Association of State Boards of Education
  www.nasbe.org/HealthySchools/States/State_Policy.html
- School Health Resource Database
  National School Boards Association
  www.nsba.org/site/page_schoolhealth_search.asp?TRACKID=&CID=1116&DID=12022#
- State Legislative Information – Database for Nutrition and Physical Activity
  Centers for Disease Control and Prevention
  http://apps.nccd.cdc.gov/DNPALeg

Quality Health Education

- Health Education Curriculum Analysis Tool (HECAT)
  To be published by Centers for Disease Control and Prevention in 2004
- National Health Education Standards*:* Achieving Health Literacy
  American Association for Health Education, American Cancer Society, American School Health Association
  www.ashaweb.org/cgi-bin/Web_store/web_store.cgi (Click on "Online Store")
  www.aahperd.org/aahe/pdf_files/standards.pdf
- State Collaborative on Assessment and Student Standards: Health Education Assessment Project
  Council of Chief State School Officers
  www.ccsso.org/publications

Supplemental Health Education Materials

- Media Sharp
  Centers for Disease Control and Prevention
  www.cdc.gov/tobacco/mediashrp.htm
- Media-Smart Youth: Food, Fitness, and Fun!
  To be published by National Institute of Child Health and Human Development in 2004
- Parenting Kit: Got a Minute? Give It to Your Kid
  Centers for Disease Control and Prevention
  www.cdc.gov/tobacco/parenting
- Scene Smoking
  Centers for Disease Control and Prevention
  http://www.cdc.gov/tobacco/celebrities/scenesmoking.htm

- SmokeScreeners
  Centers for Disease Control and Prevention
  www.cdc.gov/tobacco/smokescreen.htm
- Team Nutrition Resources
  U.S. Department of Agriculture
  http://www.fns.usda.gov/tn/
- The Power of Choice: Helping Youth Make Healthy Eating and Fitness Decisions, A Leader's Guide
  United States Department of Agriculture and Food and Drug Administration
  http://www.fns.usda.gov/tn/Resources/power_of_choice.html

Quality Physical Education

- Moving Into the Future – National Standards for Physical Education
  National Association for Sport and Physical Education
  www.aahperd.org/naspe/template.cfm?template=publications-nationalstandards.html
- Physical Education Curriculum Analysis Tool
  To be published by Centers for Disease Control and Prevention in 2004
- Resources from the National Association for Sport and Physical Education
  www.aahperd.org/
- The Community Guide Recommendations: Increasing Physical Activity
  Taskforce on Community Preventive Services
  www.thecommunityguide.org/pa/pa-MMWR-recs.pdf

Additional Opportunities for Physical Activity

- Elementary school recess games & activities
  The American Association for the Child's Right to Play
  www.ipausa.org/elemrecessbook.htm
- Kids Walk to School: A Guide to Promote Walking to School
  Centers for Disease Control and Prevention
  www.cdc.gov/nccdphp/dnpa/kidswalk/index.htm
- Guidelines for Intramural Sports
  National Association for Sport and Physical Education
  www.aahperd.org/naspe/pdf_files/pos_papers/intramural_guidelines.pdf
- Take 10 classroom physical activity breaks
  International Life Sciences Institute
  www.take10.net
- The case for elementary school recess
  The American Association for the Child's Right to Play
  www.ipausa.org/recesshandbook.htm
- VERB: It's what you do.
  Centers for Disease Control and Prevention
  - Partners (including schools): www.cdc.gov/VERB
  - Tweens: www.VERBnow.com
  - Parents: www.VERBparents.com
- Walk to School Day
  www.walktoschool-usa.org/

Quality School Meals

- Fruits & Vegetables Galore

To be published by United States Department of Agriculture and National Cancer Institute in spring 2004

- Healthy School Meals Resource System
  United States Department of Agriculture
  http://schoolmeals.nal.usda.gov
- Keys to Excellence in School Food and Nutrition Programs
  American School Food Service Association
  www.asfsa.org/keys/
- Resources from the National Food Service Management Institute
  The University of Mississippi
  www.nfsmi.org/Information/resourceguide.pdf

Healthy School Nutrition Environment

- Action for Healthy Kids
  www.actionforhealthykids.com
- Changing the Scene– Improving the School Nutrition Environment
  United States Department of Agriculture
  www.fns.usda.gov/tn/Resources/changing.html
- Making It Happen: School Nutrition Success Stories
  To be published by Centers for Disease Control and Prevention & United States Department of Agriculture in 2004

Tobacco-Free School

- Best Practices for Comprehensive Tobacco Control Programs
  Centers for Disease Control and Prevention
  www.cdc.gov/tobacco/bestprac.htm
- Taking an Action Against Secondhand Smoke: An Online Toolkit
  Centers for Disease Control and Prevention
  www.cdc.gov/tobacco/ETS_Toolkit/index.htm
- Tobacco-Free Sports Playbook
  Centers for Disease Control and Prevention
  www.cdc.gov/tobacco/sport_initiatives.htm

Asthma-Friendly School

- Asthma-Friendly Schools Toolkit
  American Lung Association
  http://www.lungusa.org/afsi/index.html
- Asthma Wellness: Keeping Children with Asthma in Schools and Learning
  American Association for School Administrators
  School Governance and Leadership, Spring 2003
  http://www.aasa.org/publications/sgl/Spring_2003.pdf
- Indoor Air Quality (IAQ) Tools for Schools Kit
  Environmental Protection Agency
  http://www.epa.gov/iaq/schools/toolkit.html
- Managing Asthma: a Guide for Schools
  National Heart, Lung, and Blood Institute
  http://www.nhlbi.nih.gov/health/prof/lung/asthma/asth_sch.htm
- Quest for the Code: CD-ROM Game
  STARBRIGHT Foundation
  http://www.starbright.org/projects/asthma/index.htm

APPENDIX I
Virginia Department of Education Divisions by Health Districts

Alexandria Health District

Charles Konigsberg, MD, MPH
District Director
517 North Saint Asaph St.
Alexandria, VA 22314
703-838-4400 Office
703-838-4038 Fax

School Division
Alexandria

Alleghany Health District

Molly L. O'Dell, MD
District Director
Academy Street, PO Box 220
Fincastle, VA 24090
540-473-8240 Office
540-473-8242 Fax

School Divisions
Alleghany
Botetourt
Covington
Craig
Roanoke County
Salem

Arlington Health District

Susan M. Allan, MD, JD, MPH
District Director
1800 North Edison Street
Arlington, VA 22207
703-228-4992 Office
703-228-5233 Fax

School Division
Arlington

Central Shenandoah Health District

G. Douglas Larsen, MD
District Director
1414 North Augusta Street
P.O. Box 2126
Staunton, VA 24402-2126
540-332-7830 Ext. 65 Office
540-885-0149 Fax

School Divisions
Augusta
Bath
Buena Vista City
Harrisonburg City
Highland
Lexington
Rockbridge
Rockingham
Staunton City
Waynesboro City

Central Virginia Health District

Joanna H. Harris, MD
District Director
1900 Thomson Drive
P.O. Box 6056
Lynchburg, VA 24505
434-947-6777 Office
434-947-2338 Fax

School Divisions
Amherst
Appomattox
Bedford
Campbell
Lynchburg City

Chesapeake Health District

Nancy Welch, MD, MHA, MBA
District Director
748 Battlefield Blvd., North
Chesapeake, VA 23320
757-382-8600 Office
757-547-0298 Fax

School Division
Chesapeake

Chesterfield Health District

William R. Nelson, MD, MPH
District Director
9501 Lucy Corr Circle
P.O. Box 100
Chesterfield, VA 23832
804-748-1743 Office
804-751-4497 Fax

School Divisions
Chesterfield
Colonial Heights City
Powhatan

Crater Health District

Michael O. Royster, MD, MPH
District Director
301 Halifax Street
P.O. Box 2081
Petersburg, VA 23804
804-863-1652 Office
804-862-6126 Fax

School Divisions
Dinwiddie
Greensville
Hopewell
Petersburg
Prince George
Surrey
Sussex

Cumberland Plateau Health District

John J. Dreyzehner, MD, MPH
District Director
155 Rogers Street
P.O. Box 2347
Lebanon, VA 24266
276-889-7621 Office
276-889-7625 Fax

School Divisions
Buchanan
Dickenson
Russell
Tazewell

Eastern Shore Health District

Michael Margolius, MD, MPH
District Director
23191 Front Street
P.O. Box 177
Accomac, VA 23301-0177
757-787-5880 Office
757-787-5841 Fax

School Divisions
Accomack
Northampton

Fairfax Health District

Gloria Addo-Ayensu, MD, MPH
District Director
10777 Main Street, Ste. 203
Fairfax, VA 22030
703-246-2479 Office
703-273-0825 Fax

School Divisions
Fairfax
Falls Church

Hampton Health District

S. William Berg, MD, MPH
District Director
Hampton Health District
3130 Victoria Blvd.
Hampton, VA 23661-1588

757-727-1172 Office
757-727-1185 Fax

School Division
Hampton

Hanover Health District
W. Ted Tweel, MD, MPH
District Director
12312 Washington Hwy.
Ashland, VA 23005
804-365-4313 Office
804-365-4355 Fax

School Divisions
Charles City
Goochland
Hanover
New Kent

Henrico Health District
Curtis W. Thorpe, MD, MPH
District Director
8600 Dixon Powers Drive
Richmond, VA 23228
P.O. Box 27032
Richmond, VA 23273
804-501-4522 Office
804-501-4983 Fax

School Division
Henrico

Lenowisco Health District
E. Sue Cantrell, MD
District Director
134 Roberts Street, S.W.
Wise, VA 24293
276-328-8000 Office
276-376-1020 Fax

School Divisions
Lee
Norton
Scott
Wise

Lord Fairfax Health District
Diana R. Helentjaris, MD, MPH
District Director
107 N. Kent St., Suite 201
Winchester, VA 22601
540-722-3480 Office
540-722-3479 Fax

School Divisions
Clarke
Frederick
Page
Shenandoah
Warren
Winchester

Loudoun Health District
David Goodfriend, MD, MPH
District Director
1 Harrison Street, S.E.
P. O. Box 7000
Leesburg, VA 20177
703-777-0234 Office
703-771-5023 Fax

School Division
Loudoun

Mount Rogers Health District
D. Craig Smith, MD, MPH
District Director
201 Francis Marion Lane
Marion, VA 24354-4227
276-781-7450 Office
276-781-7455 Fax

School Divisions
Bland
Bristol
Carroll
Galax
Grayson
Smyth
Washington
Wythe

New River Health District

Jody H. Hershey, MD, MPH
District Director
210 South Pepper Street, Suite A
Christiansburg, VA 24073
540-381-7100 Office
540-381-7108 Fax

School Divisions
Giles
Floyd
Montgomery
Pulaski
Radford

Norfolk Health District

Valerie Stallings, MD, MPH
District Director
830 Southampton Ave. Ste. 200
Norfolk, VA 23510
757-683-2796 Office
757-683-8878 Fax

School Division
Norfolk

Peninsula Health District

Elaine Perry, MD
416 J. Clyde Morris Boulevard
Newport News, VA 23601
757-594-7305 Office
757-594-7714 Fax

School Divisions
James City County
Newport News
Poquoson
Williamsburg
York

Piedmont Health District

Mark J. Levine, MD, MPH
District Director
Piedmont Health District
111 South Street, 1st Flr.
Farmville, VA 23901
434-392-3984 Office
434-392-1038 Fax

School Divisions
Amelia
Buckingham
Charlotte
Cumberland
Lunenburg
Nottoway
Prince Edward

Pittsylvania/Danville Health District

M. Geoffrey Smith, MD, MPH
District Director
326 Taylor Drive
Danville, VA 24541
434-799-5190 Office
434-799-5022 Fax

School Divisions
Danville City
Pittsylvania

Portsmouth Health District

Demetria Lindsay, MD
1701 High Street, Suite 102
Portsmouth, VA 23704
757-393-8585 Office
757-393-8027 Fax

School Division
Portsmouth

Prince William Health District

Jared E. Florance, MD
District Director
9301 Lee Avenue
Manassas, VA 20110
703-792-6300 Office
703-792-6338 Fax

School Divisions
Manassas City
Manassas Park
Prince William

Rappahannock Health District

Donald R. Stern, MD, MPH
District Director
608 Jackson Street
Fredericksburg, VA 22401
540-899-4797 Office
540-899-4599 Fax

School Divisions
Caroline
Fredericksburg City
King George
Spotsylvania
Stafford

Rappahannock/Rapidan Health District

Lilian Peake, MD, MPH
District Director
640 Laurel Street
Culpeper, VA 22701-3993
540-829-7350 Office
540-829-7345 Fax

School Divisions
Culpeper
Fauquier
Madison
Orange
Rappahannock

Richmond City Health District

William R. Nelson, MD, MPH
Acting District Director
900 E. Marshall Street, 3rd floor
Richmond, VA 232l9
804-646-3153 Office
804-646-3111 Fax

School Division
Richmond City

Roanoke City Health District

Molly L. O'Dell, MD
District Director
515 Eighth Street, SW
Roanoke, VA 24016
540-857-7600 Office
540-857-6987 Fax
School Division

School Division
Roanoke City

Southside Health District

Leland Spencer, MD, MPH
District Director
434 Washington Street
P. O. Box 560
Boydton, VA 23917
434-738-6815 Ext. 100 Office
434-738-6295 Fax

School Divisions
Brunswick
Halifax
Lunenburg
Mecklenburg
Nottoway
Prince Edward

Thomas Jefferson Health District

Susan L. McLeod, MD, MPH
District Director
1138 Rose Hill Drive-22903
P.O. Box 7546
Charlottesville, VA 22906
434-972-6219 Office
434-972-4310 Fax

School Divisions
Albemarle
Charlottesville
Fluvanna
Greene
Louisa
Nelson

Three Rivers Health District

Reuben Varghese, MD
District Director
2780 Puller Hwy, POB 415
Saluda, VA 23149

804-758-2381 Office
804-758-4828 Fax

School Divisions
Colonial Beach
Essex
Gloucester
King and Queen
King William
Lancaster
Mathews
Middlesex
Northumberland
Richmond County
Westmoreland
West Point

Virginia Beach Health District

Venita Newby-Owens, MD, MPH
District Director
Pembroke Corporate Center III
4452 Corporation Lane
Virginia Beach, VA 23462
757-518-2700 Office
757-518-2640 Fax

School Division
Virginia Beach City

West Piedmont Health District

Edward Van Oeveren, MD, MPH
District Director
295 Commonwealth Blvd.
P.O. Box 1032
Martinsville, VA 24114
276-638-2311 Office
276-638-3537 Fax

School Divisions
Franklin County
Henry County
Martinsville City
Patrick County

Western Tidewater Health District

Lawrence Gernon, MD, MPH&TM
District Director
1217 North Main Street
P.O. Box 1587
Suffolk, VA 23439-1587
757-686-4900 Office
757-925-2243 Fax

School Divisions
Franklin City
Isle of Wight
Southampton
Suffolk

Unlimited
nonprofit duplication
is permitted.

The Virginia Department of Education does not unlawfully discriminate on the basis of sex, race, color, religion, disabilities, or national origin in employment or in its educational programs and activities.